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**Doctoral Thesis**

# An Exploration of the Eating Disorder Voice Continuum and its Impact on Recovery

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| Critical Appraisal | 3986 | 1925 | 5911 |
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# Thesis Abstract

Section one presents a systematic literature review exploring the effectiveness of interpersonal and relational based interventions in eating disorder treatment. Four databases were systematically searched, and 22 papers were synthesised using an abridged Synthesis Without Meta-analysis. Findings highlighted two effective interventions: Interpersonal Psychotherapy and Compassion Focused Therapy. These interventions produced comparable treatment outcomes to Cognitive Behavioural Therapy and offered a more stable recovery. Similar mechanisms underpin these interventions as they directly address underlying maintaining factors within the self. Clinical implications and directions for future research are discussed.

Section two details a qualitative exploration of voice personification and multiplicity alongside the Eating Disorder Voice in young women experiencing an Eating Disorder. A three-layered adapted Experience-Based Co-Design approach was implemented. Initial analysis of data gathered in layer one and two was presented within layer three to obtain participant's feedback on the interpretation of their stories. Eleven stories of lived experience were then analysed using Narrative Analysis. Three chapters emerged: (1) A Continuum of the Eating Disorder Voice experiences, (2) Conflict between the Self and the Eating Disorder Voice, and (3) The role of an Eating Disorder Voice in the maintenance of an Eating Disorder. Findings indicate a continuum of the Eating Disorder Voice, including experiences of voice personification and multiplicity. Furthermore, the results demonstrate how the relationship with an Eating Disorder Voice maintains an eating disorder. Clinical implications are discussed, including adapting eating disorder treatment to reflect the continuum of Eating Disorder Voice experiences.

Section three contains a critical appraisal, which discusses the methodological and ethical decisions and issues that arose while conducting the empirical paper. The paper also offers personal reflections and insights into the process of collaborative research and the importance of listening to an unheard population. For a glossary of key terms within this thesis see Appendix 3-A.

# Declaration

This thesis presents research conducted between October 2022 and March 2024 in partial fulfilment of the Doctorate in Clinical Psychology at Lancaster University. The work submitted is the authors own and does not contain the work of any other authors, except where due reference is made. This thesis has not been submitted for the award of any higher degree elsewhere.

Phoebe Dale

08.03.24

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## Section One: Systematic Literature Review

# Exploring the Effectiveness of Relational and Interpersonal Interventions in Treating Eating Disorders: A Systematic Review

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# Abstract

**Objective:** 1.25 million people in the UK are living with an eating disorder (ED). EDs cause this population to be more at risk of mortality than the general population. Interpersonal and relational based ED treatments may help to address interpersonal challenges and the relationship with the self, others and potentially the ED that may be underlying the individual's difficulties. A recent literature review concluded that addressing the eating disorder voice (EDV) phenomena through relational and interpersonal interventions could improve ED treatment outcomes. Therefore, this review aims to synthesise the existing quantitative literature on interpersonal and relational interventions to establish a novel understanding of their effectiveness in treating EDs.

**Method:** A comprehensive search was conducted through PsycINFO, PsycArticles, MEDLINE and CINAHL, which yielded 22 studies. The included papers' samples accounted for 1,895 participants (82% female identifying), aged between 17-77-years-old and based in the USA, UK, Sweden, and Canada. A suitably abridged Synthesis Without Meta-analysis (SWiM) was conducted to analyse the papers, which facilitated transparency in the reporting of the synthesis. Selected papers for review were grouped by intervention and then ED diagnosis.

**Results:** The synthesis highlighted two prominent interventions as particularly effective; Interpersonal Psychotherapy (IPT) and Compassion Focused Therapy (CFT), which produced comparable treatment outcomes to Cognitive Behavioural Therapy (CBT), with the added value of more stable recovery within a follow up period.

**Conclusions:** This review raises the question of whether current treatment pathways are effectively addressing maintaining factors in EDs. Future research should examine the long-term outcomes of IPT and CFT to solidify their evidence bases. Additionally, further qualitative research is needed to understand the EDV phenomenon as a maintaining factor for EDs to further help inform interventions and treatment pathways in ED services.

## Highlights

- By addressing interpersonal problems rather than ED symptoms directly, IPT produces comparable and potentially more stable treatment outcomes to CBT.
- There are promising results of the effectiveness of CFT in reducing individual's reliance on ED behaviours by improved emotional regulation and self-compassion.
- There is currently a lack of quantitative research examining whether interpersonal and relational interventions can effectively address the EDV.

*Keywords: eating disorders, interpersonal interventions, relational interventions, systematic review*

## Introduction

The number of young people accessing treatment for eating disorders (ED) has increased by 25% from 2021 to 2022 (NHS England, 2022). In 2024 Beat, the UK's leading ED charity, reported that 1.25 million people in the UK are living with an ED (Beat, n.d.). EDs are classified as a mental health condition where the control of food is used as a coping mechanism for the individual's feelings and their external environment, which may be causing them distress (Branley-Bell & Talbot, 2021). A defining feature of EDs is the presence of negative beliefs about oneself, the body, eating, and weight. These beliefs contribute to the development of behaviours such as restricted eating, binge eating and compensatory behaviours, such as induced vomiting (National Institute for Health and Care Excellence [NICE], 2017).

The presence of different ED behaviours determines the individual's diagnosis. Although different EDs share many similarities, typical diagnostic categories within the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013) include Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder (BED), Eating Disorder Not Otherwise Specified (EDNOS)[1], Avoidant Restrictive Food Intake Disorder (AFRID), Pica and Rumination Disorder. The psychological and physical impact of these negative beliefs and behaviours often maintains the ED difficulties, resulting in people with an ED being up to 5.35 times more at risk of mortality from malnutrition and suicide compared to the general population (Cliffe et al., 2020; Fichter & Quadflieg, 2016; Mitchell & Crow, 2006). Consequently, the effective treatment of EDs and prevention of relapse is a clinical priority.

The vicious cycle of using ED behaviours as a coping mechanism, which inadvertently reinforces these behaviours, results in poor treatment outcomes and significant relapse rates within

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[1] In 2013, the diagnosis "Eating Disorder Not Otherwise Specified" was changed to "Other Specified Feeding or Eating Disorder" (OSFED) in the fifth edition of the Diagnostic and Statistical Manual. The language used within this literature review reflects the diagnostic terms utilised within the literature.

this population. The low rates of reaching and maintaining recovery is a consistent issue across different ED diagnoses, with BED demonstrating remission rates in adults between 52-62%, and a relapse rate of 20-60% (Kober & Boswell, 2018; Wilson et al., 2010), and the relapse rates for anorexia nervosa in female adults ranging from 9% to 65% (Carter et al., 2004; Keel et al., 2005; Walsh et al., 2006). Possible explanations for this wide range in relapse rates may be the diverse number of interventions examined or the varied samples included, as research has shown that adults with a longer duration of an ED were less likely to benefit from psychological treatment due to their reliance on ED behaviours being more entrenched (Cooper et al., 2016). The current NICE guidance for the treatment of EDs recommends Cognitive Behavioural Therapy (CBT), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) or Specialist Supportive Clinical Management as the interventions for adults diagnosed with anorexia nervosa. For adults diagnosed with BED and bulimia nervosa guided self-help or CBT are recommended. Family Therapy is also recommended for young people diagnosed with anorexia nervosa and bulimia nervosa (NICE, 2017). However, the poor treatment outcomes and significant relapse rates may suggest that the interventions currently offered for EDs are not addressing crucial maintaining factors, such as the eating disorder voice (EDV).

In the last decade, research has highlighted a common voice-hearing phenomena experienced by 94.5% of those living with an ED (Noordenbos et al., 2014). The phenomena, coined the EDV, is typically an internally based voice that comments primarily on the person’s eating, body shape, and weight (Pugh, 2016). The term encapsulates wider voice-hearing experiences for people with EDs, such as the ‘anorexic voice’ which is specific to people with anorexia nervosa. The anorexic voice instructs the individual to restrict their eating to achieve a lower body weight (Pugh & Waller, 2017), whereas the EDV may comment negatively on eating behaviours or body image more broadly. Accounts of the EDV phenomena demonstrate that during early stages of an ED, the voice is perceived as a source of companionship. Over time, the voice can shift to a critical and controlling entity, which individuals compare to an abusive relationship (Noordenbos & Van Geest, 2017). This relationship causes the person to feel entrapped by the EDV, and is associated with feelings of fear, loneliness, helplessness, and unworthiness (Tierney & Fox, 2010; Williams et al., 2016; Williams & Reid, 2012). As the EDV demands obedience from the individual to engage with ED behaviours, it subsequently plays a crucial role in the maintenance of negative eating patterns, including negative beliefs and compensatory behaviours (Pugh & Waller, 2017). The relative power held by the EDV has been shown to positively relate to increased severity of an ED and negative eating behaviours (Noordenbos et al., 2014; Pugh & Waller, 2016). Although little is known about the aetiology of the EDV, research has hypothesised that improving an individual's belief about their EDV and their ability to respond to it could moderate the relationship and reduce the perpetuating power the EDV has on the ED behaviours (Pugh, 2016). In summary, research has identified the EDV is a contributing factor across an individual's journey of living with an ED and the inclusion of addressing the EDV within treatment has the potential to aid recovery. The presence of a relationship with the EDV is why relational and interpersonal therapies may be particularly effective.

Research exploring whether altering the relationship with the EDV reduces ED behaviours is beginning to emerge. A literature review conducted by Duncan et al. (2015) highlighted that for those diagnosed with anorexia nervosa, regaining control by challenging the EDV's negative statements in treatment enabled participants to understand that their ED behaviours do not provide them with control, allowing them to reject the EDV and move towards recovery. Furthermore, a qualitative study interviewing women in recovery from anorexia nervosa highlighted that an increased sense of self shifted the power held by the EDV back to themselves, which enabled them to regain control (Jenkins & Ogden, 2012). More recently, preliminary findings suggest that interventions such as Voice Dialogue, which can focus directly on the EDV within treatment, could be effective in altering the relationship between the person and their EDV, to increase motivation for recovery (Chua et al., 2022). Therefore, integrating this intervention into treatment pathways may improve treatment outcomes.

Voice dialogue is also an effective intervention for those experiencing psychosis (Hayward et al., 2017). The EDV shares phenomenological similarities with pseudo-hallucinations as it is an internally based experience rather than externally generated (Pugh & Waller, 2017). Yet, it differs from pseudo-hallucinations as the EDV may shift between inner speech and auditory hallucinations on the continuum model of voice-hearing (Baumeister et al., 2017; Pugh, 2016; Pugh et al., 2018). It is worth noting that the studies that explored addressing the EDV within ED treatment focused on anorexia nervosa exclusively, and further research is needed to understand this difficulty that impacts recovery from the wide spectrum of ED diagnoses.

As research exploring the EDV is in its infancy, Aya et al. (2019) aimed to synthesise the available literature through a systematic literature review, to identify gaps within our knowledge and understanding of the EDV. They concluded that addressing the EDV by implementing relational and interpersonal approaches within ED treatment has the potential to improve treatment outcomes. Relational and interpersonal approaches differ from the recommended treatment of CBT as they focus on addressing the role of relationships and interpersonal challenges, within the self and with others, on an individual's difficulties  (Markowitz & Weissman, 2012; Wachtel, 2007), rather than dysfunctional cognitions and behaviours (Kennerley et al., 2016). Therefore, building upon the recommendations from Aya et al (2019), the present systematic literature review aims to review and report on the effectiveness of interpersonal and relational based interventions for people with an ED. By synthesising the existing research focused on these approaches, this literature review will establish a novel and timely account of the effectiveness of interpersonal and relational based interventions in treating EDs and identify priorities for future research to improve efficacy and access within NHS services. An initial scoping search highlighted there was not enough qualitative research within this field to conduct a mixed methods literature review. Furthermore, quantitative research, which can indicate measurable changes of ED behaviours following completion of interventions, may provide more insight into the effectiveness of interpersonal and relational based interventions. Therefore, this literature synthesised solely the quantitative research available within this field.

## Methods

This systematic review was prospectively registered on PROSPERO (ID: CRD42022371211) prior to commencing literature searches and is reported in line with the PRISMA 2020 guidelines (Page et al., 2021).

### Eligibility Criteria

Quantitative studies that reported the outcomes for either relational or interpersonal interventions for EDs were eligible for inclusion. Papers were excluded if they were secondary literature, were not published in English, if a full-text version was not available or if they had not been peer reviewed. All participants within studies required an ED diagnosis to be included, however there were no restrictions on age. The following diagnoses were excluded: AFRID, Pica, Rumination Disorder and, Orthorexia. These terms were excluded because Orthorexia is not currently recognised as a separate ED and the remainder of the excluded diagnoses are characterised as feeding disorders as they can be diagnosed in the absence of body image disturbances (Goday et al., 2019). Interventions that were interpersonal and relational based were included (See Appendix A). Despite being a third wave approach, Compassion Focused Therapy was included as a relational based intervention due to the themes of flows of compassion towards the self and others, and the development of compassionate other. It's inclusion and the weighting of the terms included within these intervention categories were critically reflected on within supervision as they may have informed the review. Studies that utilised behavioural based interventions, e.g., CBT, Dialectical Behavioural Therapy (DBT) and Acceptance and Commitment Therapy were excluded because they do not target interpersonal or relational difficulties within the intervention. Furthermore, interpersonal, or relational interventions that were integrated with behavioural approaches were also excluded to ensure this literature review is the first to present the effectiveness of interpersonal and relational based interventions in isolation from other approaches.

### Information Sources and Search Strategy

Studies were obtained in November 2022 by searching the following databases: APA PsycINFO, APA PsycArticles, MEDLINE Complete and CINAHL. A Boolean search strategy was generated with the support of the Health and Medicine Faculty Librarian, John Barbrook (See Appendix B). To capture the relevant studies, three search terms were expanded upon: Eating Disorders, relational interventions, and interpersonal interventions. These individual search terms were tested and adapted to ensure they were highly sensitive, and subsequently combined to create the finalised Boolean searches. The searches focused on title/abstract/keywords to identify relevant studies and was repeated across the four databases.

### Synthesis Methods

A Synthesis Without Meta-analysis (SWiM) methodology (Campbell et al., 2020) was followed, which was beneficial because it allows transparent reporting of a recognised synthesis method of quantitative studies. However, the original SWiM method was adapted by excluding stages of the method that involved additional analysis of the data, to achieve a synthesis in accordance with DClinPsy course requirements. This adaptation was agreed through discussions with members of the DClinPsy course and in supervision.

The adjusted methodology involved dividing the studies for review into an interpersonal focused group and a relational focused group to ensure the review addressed its proposed question. Papers were then further grouped by the specific ED diagnosis where appropriate (See Appendix C). The papers were reviewed to establish a standardised metric; a measure used consistently across the papers when reporting the effectiveness of interventions to allow for a comparison between results to be made. It was established that 72.7% of the selected papers utilised the Eating Disorder

Examination Interview (EDE-I) (Cooper & Fairburn, 1987) or the subsequently adapted Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn & Beglin, 1994). This measure provides data on the frequency of ED behaviours alongside subscales which demonstrate the severity of ED pathology. These include restraint, eating concern, shape concern and weight concern. These subscales can be combined, and the result divided by the number of subscales to obtain a “global” score. The papers that utilised this measure concluded the effectiveness of the examined intervention by comparing pre- and post-treatment scores on the EDE-Q or EDE-I. Within this review, the reported results of the standardised metric within the included papers were subsequently collated, synthesised and critiqued to assess the overall effectiveness of interpersonal and relational based interventions. The remaining results of the selected papers, which did not assess ED pathology using the standardised metric, were then reviewed and the direction of the effect for the examined intervention was considered within the synthesis.

### Quality Assessment

The Quality Assessment tool for studies with diverse designs (QATSDD) (Sirriyeh et al., 2012) was used to critique the relevance and methodological quality of the included studies (See Appendix D). The QATSDD was selected as it provides a standardised approach to assessing the quality of a collection of studies that address the same research question with various designs and approaches, compared to other tools, which require all papers to have a consistent study design such as a randomised control trial.

## Findings

### Study Selection

Initially, a total of 984 papers were retrieved and exported to EndNote20, duplicates and non-English language papers were subsequently removed. The title and abstracts of the remaining 640 papers were screened in Rayyan based on the inclusion criteria, after which 198 papers were retrieved and read in full to assess their eligibility for inclusion. The predominant reasons for articles being excluded were due to them being secondary literature articles (n=85), the outcome of the implemented intervention was not included (n=35), the intervention included was not interpersonal or relational focused (n=21), and the interventions included were integrated with CBT (n=14). Following this process, 22 papers remained for inclusion (see Appendix E.). These articles and the decision-making process behind their selection were peer reviewed, and subsequently discussed within supervision, before their inclusion was finalised.

## Quality Assessment

The scores of the QATSDD quality assessment tool of the selected papers ranged from 19 to 36, out of a maximum score of 42, indicating moderately low to high quality research. During this process, a fifth of the papers were peer reviewed and discrepancies in scores were critically discussed prior to commencing the synthesis methodology. The recommended guidance from the authors of the QATSDD demonstrates that studies with a score above 25 are at a low risk of bias, whereas those scoring below 25 are at a higher risk of bias (Sirriyeh et al., 2012). Due to there being a paucity of research within this field, there was no threshold score for papers to meet to be included in the review. However, following the initial grouping stage of the synthesis, the quality assessment scores of the papers and the associated risk of bias were reviewed to ensure interpretations from the synthesis were guided by this information and the subsequent results presented provided the appropriate weighting to papers of a higher quality.

## Study Characteristics

Prior to commencing the SWiM methodology, the characteristics of the included papers were collated (see Appendix F). The demographics of the participants, including age, gender, and ED diagnosis, were also extracted, and synthesised to determine the populations represented within this literature review. Within the articles included, all participants were adults, 82% of participants identified as female, 5% identified as male, and the gender of 13% is unknown (see figure 1).

[INSERT FIGURE 1]

### *Interpersonal Interventions Group*

In total, 16 papers, 72.7% of the included papers, focused on interpersonal interventions. Within those articles 87.5% examined the intervention Interpersonal Psychotherapy (IPT), with the remaining 12.5% of papers exploring Psychodynamic Interpersonal Psychotherapy (PIP) (see figure 2.)

[INSERT FIGURE 2]

Across the interpersonal grouping, the common ED diagnosis held by participants was BED (47%). Other diagnoses within this group included Bulimia Nervosa (38%), “Other Eating Disorder” (7%), Anorexia Nervosa (7%) and EDNOS (1%) (see figure 3.). It is worth noting that participants included in Wilfley et al. (1993), were diagnosed with “non purging bulimia nervosa”. At the time Wilfley et al. (1993) was conducted, BED had not been recognised within the DSM, it was then added under the diagnoses of EDNOS in DSM-IV (American Psychiatric Association, 1994) and later recognised as separate diagnosis in DSM-V (American Psychiatric Association, 2013). Therefore, for the purpose of this review, the participants of Wilfley et al. (1993) have been classified as diagnosed with BED, and the subsequent results were grouped and synthesised with other papers focusing on BED.

[INSERT FIGURE 3]

### *Relational Interventions Group*

The relational interventions group contained 6 papers, which demonstrated a diverse range of interventions examined: Compassion Focused Therapy (CFT) (38%), Cognitive Analytic Therapy (CAT) (25%), Psychoanalytic Psychotherapy (13%), Family Therapy (12%), and Relational Therapy (12%) (see figure 4.)

[INSERT FIGURE 4]

The ED diagnoses within the relational grouping comprised primarily of Anorexia Nervosa (60%). Other diagnoses within this group included BED (24%), Bulimia Nervosa (10%), and EDNOS (6%) (see figure 5.).

[INSERT FIGURE 5]

## Results of Synthesis

### *Interpersonal Interventions*

#### *Bulimia Nervosa*

All papers within this subgroup (n=5) examined the effectiveness of IPT as an intervention for Bulimia Nervosa with varying results. With the exception of Jones et al. (1993), all others utilised the standardised metric of either the EDE-I or EDE-Q which will be explored first.

When examined in a naturalistic design, where there was no control condition, Bäck et al. (2020) found that a full course of 16 sessions of IPT significantly improved all EDE-Q subscale scores. At post-treatment, 77% of the participants were considered to be remitted or have shown a reduction in their ED symptoms. However, Mitchell et al. (2002) found that when IPT was compared to a course of antidepressants (fluoxetine, or desipramine), there was no significant difference in abstinence rates of bingeing and purging behaviours between the conditions. Participants within this research study had been categorised as “non-responders” to previous CBT treatment. Furthermore, the data provided was incomplete, as recovery within this paper was based solely on abstinence rates as other post-treatment EDE-I subscale scores were not available. In summary, when examined in isolation, IPT is deemed to be an effective treatment for EDs yet may not be more effective than a medication-based treatment pathway.

The majority of papers within this subgroup focused on comparing IPT to CBT in randomised control trials. Agras et al. (2000) found that overall CBT was more effective in reducing both binge eating and purging behaviours than IPT. A slightly higher percentage of participants classified as recovered, who had not engaged in binge eating or purging for the previous 28 days, at the end of treatment remained recovered at follow up in the CBT condition compared to the IPT condition. However, there were no significant differences between the two treatments at follow up. Furthermore, the conditions did not significantly differ on other EDE-I subscales including weight and shape concern. These results are partially consistent with Chui et al. (2007), who demonstrated that overall CBT yielded higher rates of abstinence from bulimia nervosa than IPT across all ethnicities included in the study. However, there was a significantly greater reduction in binge eating behaviours in Black African- and Caribbean heritage participants in the IPT condition. The results illustrated by Jones et al. (1993) were also consistent with Chui et al. (2007) and Agras et al. (2000). Improvements in ED behaviours were measured in this paper through self-report binge eating and purging episodes and the Eating Attitudes Test (Garner & Garfinkel, 1979), rather than the standardised metric identified in this review. Their results indicated that although IPT did decrease the frequency of binge eating and purging, this effect ceased by the fifth session yet remained stable for the remainder of the treatment. Whereas the decrease observed in the CBT condition was consistent and significantly lower rates compared to IPT were reported at the end of treatment. Overall, it was consistently reported that CBT yielded more effective treatment outcomes for bulimia nervosa than IPT.

### *Anorexia*

Both articles within this subgroup utilised a randomised control trial to compare the effectiveness of IPT, CBT and non-specific or specialist supportive clinical management (SSCM) in treating anorexia nervosa. McIntosh et al. (2005) concluded that IPT was the least effective of the three conditions. At post-treatment, the results indicated that the changes in participants' scores across the four subscales within the EDE-I were inferior in the IPT condition when compared to SSCM and CBT. These results at post-treatment are echoed by Carter et al. (2011) however, they included a follow up assessment within their study design. At this 5-year follow up, participants who had received IPT had significantly improved since post-treatment to an extent that there was no significant difference across the three conditions on the EDE-I subscales. Furthermore, a higher percentage of those who received IPT no longer suffered from symptoms of anorexia at follow up compared to CBT and SSCM.

### *Binge Eating Disorder*

The papers within this subgroup (n=6) examined the effectiveness of two interpersonal based interventions, PIP (n=2) and IPT (n=4), in the treatment of BED.

Within research conducted by Tasca et al. (2013), participants received 16 weeks of group PIP, they were matched and divided into low and high attachment anxiety groups. The researchers used the EDE-I to assess the frequency of binge eating episodes, changes in frequency indicated participants' level of improvement and recovery. Across both groups, the intervention significantly reduced the number of days binged from pre- to post-treatment, with continued improvement at a 12 month follow up. These results mirror those found in an earlier study by Tasca et al. (2006). This randomised control trial compared two group-based interventions, PIP and CBT, to a control condition. Instead of utilising the standardised metric, binge eating frequency was self-reported by participants. They found PIP and CBT achieved similar reductions in the frequency of binge eating episodes at post-treatment and follow up.

The remainder of the papers within this subgroup were randomised control trials which demonstrated consistent results regarding the effectiveness of IPT for BED. With the exception of one paper which will be outlined last, binge eating episodes were assessed by the standardised metric of the EDE-I.

In research conducted by Wilson et al. (2010) the IPT condition was compared to guided self-help CBT (CBT-gsh) and, behavioural weight loss (BWL) treatment conditions. The results found no significant difference between the conditions on binge eating frequency, at post-treatment. However, at a 2 year follow up, both IPT and CBT-gsh were able to maintain these reductions significantly more than the BWL condition. These results are partially consistent with those reported by Hilbert et al. (2012). When comparing IPT to CBT four years after treatment cessation, they found both conditions yielded comparable long-term remission rates from binge eating and significant reductions in associated ED symptoms. However, although the recovery rates of both treatments did not differ at any time point, they found IPT produced high stability in binge eating abstinence whereas those who received CBT were more likely to relapse. This was also echoed in the reduction of ED symptoms during the follow up period. These differing response rates to treatment were further investigated by Hilbert et al. (2015). Participants received either CBT-gsh, IPT, or BWL and were categorised as rapid responders if they exhibited a reduction of 70% or above in their binge eating episodes by the fourth session. If they did not, they were considered non-rapid responders. Those considered rapid responders in CBT-gsh showed significantly more improvement in their binge eating frequency than non-rapid responders. Whereas the results for the IPT were more stable with rapid and non-rapid responders having higher remission rates than non-rapid responders in CBT-gsh and BWL.

An earlier study conducted by Wilfley et al. (1993) compared group CBT and group IPT to a wait list control condition. The primary outcome within this paper was binge eating frequency, which was measured using a self-report method. The results are consistent with those outlined above, as at both post-treatment and subsequent follow up assessments the two treatment conditions had an equally reduced and stabilised binge eating frequency within participants.

### *Mixed Eating Disorder Diagnoses*

Of the included papers, three comprised of participants with varied ED diagnoses including Bulimia Nervosa, BED, EDNOS and “Other eating disorder”. Therefore, they were separated into the Mixed Eating Disorder Diagnoses subgroup.

In a study conducted by Arcelus et al. (2009), all participants were diagnosed with either bulimia nervosa or the bulimia nervosa subtype of EDNOS and received 16-sessions of IPT. The results indicated a significant reduction in all EDE-Q subscales at post-treatment with the majority of participants classified as recovered or remitted. These results remained significant three months post-treatment. The largest reductions were observed within the first eight sessions, and there was no significant difference in ED symptomatology between the mid-point review and the end of treatment. These results are supported by Arcelus et al. (2012) who compared a shortened version of IPT (10 sessions), to the original 16-session structure and a wait list control group through matched pairs samples by gender and ED diagnosis. There was no significant difference between the different length treatments, with participants in both conditions showing a reduction in all EDE-Q subscales and global score. However, when compared to CBT these results are not echoed. A randomised control trial conducted by Fairburn et al. (2015) compared participants who received either a 20-week course of CBT or IPT. Within this paper, participants were considered in remission at post-treatment if their global EDE-I score was below 1.74, a clinical threshold suggesting they would no longer meet the requirements for an ED diagnosis. Of those who received CBT, 66% were in remission at post-treatment compared to 33% of participants that received IPT. At follow up, many participants in the IPT condition made significant improvements however, the remission rates within the CBT condition remained significantly higher.

The synthesis of the included papers within the interpersonal grouping demonstrated varying results in the effectiveness of interpersonal interventions in the treatment of EDs. Despite this, grouping by ED diagnosis highlighted that interpersonal interventions were consistently reported as effective in the treatment of BED. It is worth noting that samples included within the papers comprised mainly of participants diagnosed with bulimia nervosa, or BED (Figure 4). Finally, the synthesis highlighted that improvements in IPT conditions were frequently expressed slower and consequently were not observed until follow-up.

## Relational Interventions

### *Anorexia*

Both papers within this subgroup, Treasure et al. (1995) and Dare et al. (2001), examined the effectiveness of various relational based interventions in treating anorexia nervosa. Although neither paper utilised the standardised metric, the EDE-I or EDE-Q, within their research, both used the standardised psychiatric interview (Morgan & Russell, 1975) to assess ED pathology.

In a randomised control trial, comparing a CAT treatment condition with an educational behavioural treatment (EBT) condition, Treasure et al. (1995) found at a one year follow up assessment 40% of participants who received CAT had maintained a good outcome of a body weight within 15% of the average body weight, compared to 20% in the EBT condition. Overall, there was no significant differences between the two conditions. However, these results were not supported by Dare et al. (2001). Their randomised control trial included psychoanalytic psychotherapy, CAT and family therapy compared to a routine treatment control condition. The results showed psychotherapy and family therapy produced significantly more weight gain compared to the control condition, whereas the weight gain in the CAT treatment did not meet statistical significance. The majority of the participants within this research remained abnormally underwent post-treatment.

### *Binge Eating Disorder*

Kelly and Carter (2015) conducted a randomised control trial to examine the effectiveness of a self-guided self-compassion training, derived from CFT, compared to a behavioural-based self-guided training. The EDE-Q was used to assess for ED symptoms pre- and post-treatment. The results indicated that the self-compassion training led to significant changes to the participants global EDE-Q score, and the eating and weight concerns subscales compared to the behavioural-based treatment.

Another randomised control trial focused on BED was conducted by Tantillo and Sanftner (2003), which compared relational therapy to CBT. Both treatments were a 16-week group-based intervention. The frequency of binge eating episodes was measured using a self-report method. There were no differences found between relational therapy and CBT in their overall effectiveness, with both conditions showing a significant reduction in binge eating episodes post-treatment and at follow up assessments.

### Mixed Eating Disorder Diagnoses

The samples of the two papers within this subgroup comprised of those diagnosed with anorexia nervosa, bulimia nervosa, BED and EDNOS. Therefore, they were grouped into the Mixed Eating Disorder Diagnoses subgroup. Both papers utilised the EDE-Q to measure changes in ED symptoms.

Kelly et al. (2017) conducted a randomised control trial comparing the effectiveness of CFT against a treatment as usual condition (TAU), which consisted of non-manualised therapy based on CBT and Dialectical Behavioural Therapy (DBT). The results demonstrated that participants' global EDE-Q scores significantly decreased over treatment in the CFT condition, whereas those who received TAU did not.

Williams et al. (2017) also examined the effectiveness of CFT. This paper retrospectively evaluated data from participants who had received CFT during their ED treatment. The results indicated a significant decrease across all the EDE-Q subscales and global score from pre- to post-treatment. However, the majority of participants were not considered in remission despite demonstrating clinically reliable improvement on their EDE-Q scores.

In summary, the synthesis of this grouping demonstrates that there is a paucity of research examining relational based interventions for the treatment of EDs. The key findings suggest that CFT shows promising results as an effective treatment option. Finally, the samples of the included papers comprise primarily of participants diagnosed with anorexia nervosa.

## Discussion

This systematic review aimed to synthesise and interpret the existing quantitative data exploring the effectiveness of interpersonal and relational based interventions in treating EDs. In total, 22 papers were synthesised and subsequently categorised into interpersonal and relational groups. This review provides a novel and timely contribution to clinical psychology by highlighting two prominent interventions, IPT and CFT, as effective not only in the treatment of EDs, but in potentially stabilising recovery within this high-risk population. Future research should aim to examine the long-term outcomes of IPT and CFT to further solidify their evidence bases. Overall, this review aims to help inform and improve the current treatment pathways within ED services to ensure clinicians are striving to improve the poor recovery rates from EDs.

### Interpersonal Interventions

Of the included papers, 16 focused on interpersonal interventions. The majority of these papers demonstrated that the implementation of interpersonal interventions, such as IPT and PIP, are effective in the treatment of EDs. These effects were seen in particular for the treatment of BED, which was consistently reported to respond positively to interpersonal based treatment. Whereas, for other examined diagnoses the reported treatment outcomes across the literature are more mixed. Overall, the results reported across these studies consistently evidenced that participants receiving interpersonal based treatment showed a significant reduction in their ED symptoms, and in many cases could be considered to no longer meet the diagnostic criteria for an ED diagnosis. This may be due to interpersonal based interventions improving an individual’s ability to regulate their emotions, which may have been previously managed through ED behaviours. Furthermore, six of these papers concluded that in randomised control trials, IPT or PIP achieved treatment outcomes that were as effective as the nationally recommended treatment, CBT. However, this conclusion was not consistent across the papers within this grouping as five papers reported that the outcomes produced by CBT treatment were superior to those produced by interpersonal based interventions. Therefore, these results suggest integrating interpersonal based interventions into treatment pathways alongside CBT may be beneficial, especially for those diagnosed with BED.

Upon further examination of these results comparing specifically IPT to CBT, a pattern of delayed improvement in the IPT conditions was observed. Within Carter et al. (2011), they found that IPT produced a “lag” effect in which the improvement seen in participants’ scores was expressed at a slower rate and was subsequently captured at the follow up assessment. These delayed improvements led to IPT achieving comparable outcomes to CBT. Yet, risk of bias is a potential concern within Carter et al. (2011) due to a limited sample size at the follow up assessment which may have hindered the study’s power and ability to detect small effect sizes within the group differences and therefore elevating the risk of type II errors. Alongside this, Carter et al. (2011) scored below the recommended guidance on the quality assessment tool, which further highlights the potential risk of bias. Despite these limitations, evidence of a lag effect was identified in the follow up results of papers that were deemed more sound and less at risk of bias by the quality assessment tool (Agras et al., 2000; Hilbert et al., 2012). These papers support the conclusions made by Carter et al. (2011), as they also observed a lag effect in the outcomes of IPT treatment during follow up which were equivalent to those achieved by CBT.

Additionally, of the papers that concluded CBT was the superior treatment option (n=5), three did not include a follow up assessment within their study design (Chui et al., 2007; Jones et al., 1993; McIntosh et al., 2005). Thus, it cannot be stated whether or not participants who received IPT in these studies made additional improvements, following the cessation of treatment, comparable to the outcomes within the CBT condition. However, the conclusion that IPT produced comparable results to CBT was not consistently found across the included papers that incorporated a follow up assessment. For example, Fairburn et al. (2015) demonstrated evidence of a lag effect for the IPT condition yet at follow up CBT remained the more effective treatment. Furthermore, in some papers a lag effect was not identified despite the inclusion of a follow up assessment (Arcelus et al., 2009; Wilson et al., 2010). Therefore, further research is necessary to add clarity to this field to understand this inconsistently reported lag effect in IPT interventions.

To understand potential explanations for these delayed improvements, we must first understand the relationship between interpersonal difficulties and ED symptoms. The IPT-ED model suggests that disturbances of the self, such as low self-esteem and poor self-regulation are pivotal to the development and maintenance of ED symptoms as they create a self-perpetuating cycle (Rieger et al., 2010). In an attempt to manage negative self-evaluation, people engage in ED behaviours, however these behaviours instead exacerbate interpersonal problems subsequently intensifying ED symptomatology. The aim of IPT is therefore to support improvements in the individual's interpersonal life and relationships to reduce their reliance on the ED for positive esteem (Murphy et al., 2012; Rieger et al., 2010). As IPT aims to target ED behaviours indirectly, through the route of addressing interpersonal problems, the reduction in symptoms may take longer to be expressed compared to treatments directly focused on the ED behaviours. Therefore, creating the lag effect observed periodically within the included papers. Furthermore, research has also suggested that the focus on interpersonal problems in IPT additionally prepares individuals to manage challenges in daily life and reduce a feeling of hopelessness (Bäck et al., 2020). This was supported by the included literature as IPT recipients were more stable in their recovery and less likely to relapse during the follow up period compared to those who had received CBT (Hilbert et al., 2012; Hilbert et al., 2015). In summary, due to IPT addressing difficulties beyond the presenting ED behaviours it may take longer for improvements of these symptoms to be expressed and could reduce the risk of an individual relapsing.

## Relational Interventions

Compared to the interpersonal based grouping, there was significantly less literature included within this review that examined relational based interventions. Across the six papers, five different therapeutic modalities were studied, and contradictory results reported which therefore makes it difficult to draw reliable conclusions on the effectiveness of the treatments. For example, one paper demonstrated that the implementation of CAT had increased and maintained body weight in participants (Treasure et al., 1995), whereas opposing results highlighted CAT did not significantly increase weight gain in participants when compared to psychoanalytic psychotherapy and family therapy (Dare et al., 2001). Furthermore, these three interventions were examined in the context of treating anorexia nervosa, therefore we cannot state whether consistent or opposing treatment outcomes for these interventions would be observed across the different ED diagnoses. Similarly, bulimia nervosa and EDNOS were not examined in isolation from other EDs within the included papers of this grouping (Kelly et al., 2017; Williams et al., 2017), so we cannot draw conclusions from the data on whether any relational based interventions could effectively target either of these ED diagnoses directly. Further research is necessary within this area to build and solidify the evidence bases for these interventions across the spectrum of ED diagnoses.

Despite this, one consistent result that emerged within the relational grouping was the effectiveness of CFT in treating EDs. Three of the six papers included within this grouping examined CFT-based interventions, and consistently reported a reduction in ED symptomology (Kelly & Carter, 2015; Kelly et al., 2017; Williams et al., 2017). CFT may be beneficial in the treatment of EDs as it targets lowered self-compassion, a common difficulty within the ED population, which is negatively associated with ED behaviours and shame (Ferreira et al., 2013; Kelly et al., 2014). Qualitative research has demonstrated that participants who received CFT reported the treatment enabled them to develop a compassionate understanding of their ED and a compassionate mind perspective which contributed towards their ED improving (Mullen et al., 2020). In addition to the self-compassion element of CFT, the three systems model has been in explored in relation to EDs. This model categorises emotional regulation into three systems: alertness to threat and protective systems, drive towards rewards and resources, and soothing and safety systems (Gilbert, 2009, 2014). It has been hypothesised that engaging in ED behaviours may be an attempt to regulate the impact of an overactive threat system, in the absence of an effective soothing system (Goss & Allan, 2010). Therefore, improvements to ED symptoms can be observed in CFT as it enables individuals to build an effective sooth system to create a balance between these emotional regulatory systems. This ability to activate soothing not only equips them to better regulate their overactive threat system but subsequently reduces their reliance on engaging with ED behaviours (Goss & Allan, 2014; Mullen et al., 2020).

Participants across the included papers which examined CFT represent the spectrum of ED diagnoses: anorexia nervosa, bulimia nervosa, BED and EDNOS. These diagnoses were primarily studied collectively, BED was the only diagnosis to be examined in isolation (Kelly & Carter, 2015). Although these diverse samples allow the results to be generalised across the ED diagnoses, the study's designs prevent us from comparing results between the different diagnoses. Therefore, we cannot state from these papers whether one diagnosis benefitted more from CFT than another.

Furthermore, it is important to acknowledge the quality and limitations of these papers when exploring these results. Research conducted by Williams et al. (2017) was completed retrospectively by obtaining the pre and post measures of participants who had completed CFT treatment for their ED, as a result there was no control condition included within the study design. This limits the reliability of the results obtained by Williams et al. (2017) as we cannot be certain that the reduction in ED symptomology was due to the CFT treatment and not other extraneous variables. Despite this, results are supported by further randomised control trials which demonstrated CFT significantly reduced ED symptoms (Kelly & Carter, 2015; Kelly et al., 2017), these papers were deemed to be at low risk of bias by the quality assessment tool utilised within this review. However, we cannot conclude whether the improvements in ED symptomology observed from CFT treatment are maintained long-term, as there were no follow up assessments completed within these papers. Therefore, future research may benefit from implementing a longitudinal design within a randomised control trial. Research of this nature would enable the authors to effectively conclude the long-term implications of receiving CFT treatment for EDs compared to a control condition. However, it would be imperative to control and monitor alternative treatments and interventions accessed by participants during the long-term follow up period to ensure the long-term outcomes observed can be attributed to CFT treatment in isolation.

## Clinical Implications and Future Research

It is evident that similar mechanisms underpin interpersonal and relational based interventions, in particular IPT and CFT; namely both interventions look beyond the ED behaviours to address maintaining factors within the self, such as low self-esteem, and self-compassion. The results of this review highlight that the therapeutic processes of growing a compassionate self in CFT or resolving interpersonal struggles within IPT equips participants with the means to overcome challenging situations or relationship difficulties without the reliance of ED behaviours, therefore these interventions indirectly reduce ED symptomology (Ferreira et al., 2013; Rieger et al., 2010). These therapeutic processes have the potential to result in a more stable recovery from an ED (Hilbert et al., 2012; Hilbert et al., 2015) and potentially reduce the risk of relapse. The rate of relapse is a significant issue across ED diagnoses with reported rates of up to 65% (Carter et al., 2004; Keel et al., 2005; Kober & Boswell, 2018; Strober et al., 1997; Walsh et al., 2006; Wilson et al., 2010). Although CBT may be considered more cost effective due to its delivery of more immediate results post-treatment (Chui et al., 2007; Jones et al., 1993; McIntosh et al., 2005), it is necessary that long-term outcomes are equally prioritised to ensure the risk of relapse is curbed. However, for interventions such as IPT and CFT to be considered equal to the current nationally recommended treatment, CBT, further research examining whether these interventions can support relapse prevention within this high-risk population long-term is needed to clarify and subsequently solidify the current evidence bases. Additionally, the samples included within the current evidence base for

IPT and CFT were predominately white females with varied ED diagnoses thus, the results of this synthesis cannot be generalised to a wider ethnically diverse population. Clinical Psychologists within ED services should be striving for inclusive practice and ensuring the treatment provided is person centred and evidence based for the client's demographics. To achieve this, further research implementing realist methods, which aims to identify underlying causal mechanisms to understand how an intervention works, why and for whom to establish what interventions are effective for different diagnoses in different populations (Rycroft-Malone et al., 2012), is necessary.

## Addressing the Eating Disorder Voice in Clinical Research and Practice

A recent review conducted by Aya et al. (2019) concluded that further exploration into interpersonal and relational based interventions that address the EDV is needed. However, this review did not capture any papers that focused on this intersection of ED treatment, despite the growing evidence that demonstrates experiencing an EDV plays a crucial role in the maintenance of ED behaviours (Pugh & Waller, 2017). The gap in the literature highlighted by this review could be addressed by future qualitative research implementing an Experience Based Co-Design. This design would capture the experiences of individuals with an EDV to further understand the phenomenon and help to collaboratively inform and improve upon the current interventions and treatment pathways offered within ED services.

As previously mentioned, preliminary qualitative results were published examining the effectiveness of addressing the EDV through the relational based intervention Voice Dialogue (Chua et al., 2022). They concluded that this intervention could be effective in altering the relationship the individual has with their EDV. However, these conclusions were drawn from the participant's experience of a single Voice Dialogue session and there is currently no data to support whether this intervention addressing the EDV could effectively reduce ED symptoms. To my knowledge, at the time of this review, there has been no quantitative research published focusing on addressing the EDV within interpersonal or relational based ED treatments. Therefore, it may be beneficial for future research to build upon the existing literature by conducting a randomised control trial for Voice Dialogue treatment or integrate elements which focus on the relationship with the EDV into interventions such as IPT or CFT.

## Conclusion

This literature review synthesises the findings of quantitative studies investigating the effectiveness of interpersonal and relational based interventions for the treatment of EDs. The results highlight that IPT and CFT consistently produced comparable outcomes to CBT. Compared to CBT, these interventions indirectly address ED symptoms through maintaining factors, such as poor self-esteem and low self-compassion. IPT and CFT could therefore support improved longer-term outcomes for a population with high clinical risk and mortality rates, which is why future research should prioritise these approaches. To solidify the evidence bases of these interventions further research implementing a longitudinal design and realist methods are necessary to determine long-term outcomes and the appropriateness of interventions for different ED diagnoses and populations. There are currently 1.25 million people in the UK alone living with an ED, with this number rising every year. The rate of relapse within this population is up to 65%, which raises the question of whether current treatment pathways are effectively addressing crucial maintaining factors, such as the EDV. It is evident that ED services should incorporate therapeutic approaches that emphasis working with interpersonal difficulties and the relationship with the self and others alongside the ED behaviours into their current pathways. This review encourages clinical psychologists and researchers to look beyond the presenting ED behaviours to the underlying interpersonal and relational difficulties in both clinical research and practice to ensure we are striving to improving these devasting relapse and mortality rates affecting this population.

## References

Agras, W. S., Walsh, T., Fairburn, C. G., Wilson, G. T., & Kraemer, H. C. (2000). A multicenter comparison of cognitive–behavioral therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry*, *57*(5), 459-466. https://doi.org/doi:10.1001/archpsyc.57.5.459

American Psychiatric Association, A. P. A. (1994). *Diagnostic and statistical manual of mental disorders: DSM-IV* (Vol. 4). American psychiatric association Washington, DC.

American Psychiatric Association, A. P. A. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (Vol. 5). American psychiatric association Washington, DC.

Arcelus, J., Whight, D., Brewin, N., & McGrain, L. (2012). A brief form of interpersonal psychotherapy for adult patients with bulimic disorders: A pilot study. *European Eating Disorders Review*, *20*(4), 326-330. https://doi.org/doi:10.1002/erv.2164

Arcelus, J., Whight, D., Langham, C., Baggott, J., McGrain, L., Meadows, L., & Meyer, C. (2009). A case series evaluation of the modified version of interpersonal psychotherapy (IPT) for the treatment of bulimic eating disorders: A pilot study. *European Eating Disorders Review*, *17*(4), 260-268. https://doi.org/doi:10.1002/(ISSN)1099-096810.1002/erv.v17:410.1002/erv.932

Aya, V., Ulusoy, K., & Cardi, V. (2019). A systematic review of the ‘eating disorder voice’experience. *International Review of Psychiatry*, *31*(4), 347-366.

Bäck, M., Falkenström, F., Gustafsson, S. A., Andersson, G., & Holmqvist, R. (2020). Reduction in depressive symptoms predicts improvement in eating disorder symptoms in interpersonal psychotherapy: Results from a naturalistic study. *Journal of Eating Disorders*, *8*. https://doi.org/doi:10.1186/s40337-020-00308-1

Baumeister, D., Sedgwick, O., Howes, O., & Peters, E. (2017). Auditory verbal hallucinations and continuum models of psychosis: A systematic review of the healthy voice-hearer literature. *Clinical psychology review*, *51*, 125-141.

Beat. (n.d). *About Beat*. Retrieved October 27 2023 from https://www.beateatingdisorders.org.uk/about-beat/

Branley-Bell, D., & Talbot, C. V. (2021). "It is the only constant in what feels like a completely upside down and scary world": Living with an eating disorder during COVID-19 and the importance of perceived control for recovery and relapse. *Appetite*, *167*, 105596.

Campbell, M., McKenzie, J. E., Sowden, A., Katikireddi, S. V., Brennan, S. E., Ellis, S., Hartmann-Boyce, J., Ryan, R., Shepperd, S., & Thomas, J. (2020). Synthesis without meta-analysis (SWiM) in systematic reviews: reporting guideline. *bmj*, *368*.

Carter, F. A., Jordan, J., McIntosh, V. V. W., Luty, S. E., McKenzie, J. M., Frampton, C. M. A., Bulik, C. M., & Joyce, P. R. (2011). The long-term efficacy of three psychotherapies for anorexia nervosa: A randomized, controlled trial. *International Journal of Eating Disorders*, *44*(7), 647-654. https://doi.org/doi:10.1002/eat.20879

Carter, J., Blackmore, E., Sutandar-Pinnock, K., & Woodside, D. (2004). Relapse in anorexia nervosa: a survival analysis. *Psychological medicine*, *34*(4), 671-679.

Chua, N., Serpell, L., Burnett-Stuart, S., & Pugh, M. (2022). Interviewing anorexia: How do individuals given a diagnosis of anorexia nervosa experience Voice Dialogue with their eating disorder voice? A qualitative analysis. *Clinical Psychology & Psychotherapy*, *29*(2), 600-610.

Chui, W., Safer, D. L., Bryson, S. W., Agras, W. S., & Wilson, G. T. (2007). A comparison of ethnic groups in the treatment of bulimia nervosa. *Eating Behaviors*, *8*(4), 458-491. https://doi.org/doi:10.1016/j.eatbeh.2007.01.005

Cliffe, C., Shetty, H., Himmerich, H., Schmidt, U., Stewart, R., & Dutta, R. (2020). Suicide attempts requiring hospitalization in patients with eating disorders: A retrospective cohort study. *International Journal of Eating Disorders*, *53*(5), 728-735.

Cooper, Z., Allen, E., Bailey-Straebler, S., Basden, S., Murphy, R., O'Connor, M. E., & Fairburn, C. G. (2016). Predictors and moderators of response to enhanced cognitive behaviour therapy and interpersonal psychotherapy for the treatment of eating disorders. *Behaviour Research and Therapy*, *84*, 9-13. https://doi.org/doi:10.1016/j.brat.2016.07.002

Cooper, Z., & Fairburn, C. (1987). The eating disorder examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders. *International Journal of Eating Disorders*, *6*(1), 1-8.

Dare, C., Eisler, I., Russell, G., Treasure, J., & Dodge, L. (2001). Psychological therapies for adults with anorexia nervosa: Randomised controlled trial of out-patient treatments. *The British Journal of Psychiatry*, *178*, 216-221. https://doi.org/doi:10.1192/bjp.178.3.216

Duncan, T. K., Sebar, B., & Lee, J. (2015). Reclamation of power and self: a meta-synthesis exploring the process of recovery from anorexia nervosa. *Advances in Eating Disorders: Theory, Research and Practice*, *3*(2), 177-190.

Fairburn, C. G., Bailey-Straebler, S., Basden, S., Doll, H. A., Jones, R., Murphy, R., O'Connor, M. E., & Cooper, Z. (2015). A transdiagnostic comparison of enhanced cognitive behaviour therapy (CBT-E) and interpersonal psychotherapy in the treatment of eating disorders. *Behaviour Research and Therapy*, *70*, 64-71. https://doi.org/doi:10.1016/j.brat.2015.04.010

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self-report questionnaire? *International Journal of Eating Disorders*, *16*(4), 363-370.

Ferreira, C., Pinto-Gouveia, J., & Duarte, C. (2013). Self-compassion in the face of shame and body image dissatisfaction: Implications for eating disorders. *Eating Behaviors*, *14*(2), 207-210.

Fichter, M. M., & Quadflieg, N. (2016). Mortality in eating disorders-results of a large prospective clinical longitudinal study. *International Journal of Eating Disorders*, *49*(4), 391-401.

Garner, D. M., & Garfinkel, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. *Psychological medicine*, *9*(2), 273-279.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, *15*(3), 199-208.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41.

Goday, P. S., Huh, S. Y., Silverman, A., Lukens, C. T., Dodrill, P., Cohen, S. S., Delaney, A. L., Feuling, M. B., Noel, R. J., & Gisel, E. (2019). Pediatric feeding disorder: consensus definition and conceptual framework. *Journal of pediatric gastroenterology and nutrition*, *68*(1), 124-129.

Goss, K., & Allan, S. (2010). Compassion focused therapy for eating disorders. *International Journal of Cognitive Therapy*, *3*(2), 141-158.

Goss, K., & Allan, S. (2014). The development and application of compassion-focused therapy for eating disorders (CFT-E). *British Journal of Clinical Psychology*, *53*(1), 62-77. https://doi.org/doi:10.1111/bjc.12039

Hayward, M., Jones, A.-M., Bogen-Johnston, L., Thomas, N., & Strauss, C. (2017). Relating therapy for distressing auditory hallucinations: a pilot randomized controlled trial. *Schizophrenia Research*, *183*, 137-142.

Hilbert, A., Bishop, M. E., Stein, R. I., Tanofsky-Kraff, M., Swenson, A. K., Welch, R. R., & Wilfley, D. E. (2012). Long-term efficacy of psychological treatments for binge eating disorder. *The British Journal of Psychiatry*, *200*(3), 232-237. https://doi.org/doi:10.1192/bjp.bp.110.089664

Hilbert, A., Hildebrandt, T., Agras, W. S., Wilfley, D. E., & Wilson, G. T. (2015). Rapid response in psychological treatments for binge eating disorder. *Journal of Consulting and Clinical Psychology*, *83*(3), 649-654. https://doi.org/doi:10.1037/ccp0000018 10.1037/ccp0000018.supp (Supplemental)

Jenkins, J., & Ogden, J. (2012). Becoming ‘whole’again: A qualitative study of women's views of recovering from anorexia nervosa. *European Eating Disorders Review*, *20*(1), e23-e31.

Jones, R., Peveler, R. C., Hope, R. A., & Fairburn, C. G. (1993). Changes during treatment for bulimia nervosa: A comparison of three psychological treatments. *Behaviour Research and Therapy*, *31*(5), 479-485. https://doi.org/doi:10.1016/0005-7967(93)90128-H

Keel, P. K., Dorer, D. J., Franko, D. L., Jackson, S. C., & Herzog, D. B. (2005). Postremission predictors of relapse in women with eating disorders. *The American Journal of Psychiatry*, *162*(12), 2263-2268. https://doi.org/doi:10.1176/appi.ajp.162.12.2263

Kelly, A. C., & Carter, J. C. (2015). Self-compassion training for binge eating disorder: A pilot randomized controlled trial. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(3), 285-303. https://doi.org/doi:10.1111/papt.12044

Kelly, A. C., Vimalakanthan, K., & Carter, J. C. (2014). Understanding the roles of self-esteem, self-compassion, and fear of self-compassion in eating disorder pathology: An examination of female students and eating disorder patients. *Eating Behaviors*, *15*(3), 388-391.

Kelly, A. C., Wisniewski, L., Martin-Wagar, C., & Hoffman, E. (2017). Group-Based Compassion-Focused Therapy as an Adjunct to Outpatient Treatment for Eating Disorders: A Pilot Randomized Controlled Trial. *Clinical Psychology & Psychotherapy*, *24*(2), 475-487. https://doi.org/doi:10.1002/cpp.2018

Kennerley, H., Kirk, J., & Westbrook, D. (2016). *An introduction to cognitive behaviour therapy: Skills and applications*. Sage.

Kober, H., & Boswell, R. G. (2018). Potential psychological & neural mechanisms in binge eating disorder: Implications for treatment. *Clinical psychology review*, *60*, 32-44.

Markowitz, J. C., & Weissman, M. M. (2012). Interpersonal psychotherapy: past, present and future. *Clinical Psychology & Psychotherapy*, *19*(2), 99-105.

McIntosh, V. V. W., Jordan, J., Carter, F. A., Luty, S. E., McKenzie, J. M., Bulik, C. M., Frampton, C. M. A., & Joyce, P. R. (2005). Three Psychotherapies for Anorexia Nervosa: A Randomized, Controlled Trial. *The American Journal of Psychiatry*, *162*(4), 741-747. https://doi.org/doi:10.1176/appi.ajp.162.4.741

Mitchell, J. E., & Crow, S. (2006). Medical complications of anorexia nervosa and bulimia nervosa. *Current Opinion in Psychiatry*, *19*(4), 438-443.

Mitchell, J. E., Halmi, K., Wilson, G. T., Agras, W. S., Kraemer, H., & Crow, S. (2002). A randomized secondary treatment study of women with bulimia nervosa who fail to respond to CBT. *International Journal of Eating Disorders*, *32*(3), 271-281. https://doi.org/doi:10.1002/eat.10092

Morgan, H., & Russell, G. (1975). Value of family background and clinical features as predictors of long-term outcome in anorexia nervosa: four-year follow-up study of 41 patients. *Psychological medicine*, *5*(4), 355-371.

Mullen, G., Dowling, C., Doyle, J., & O'Reilly, G. (2020). Experiences of compassion focused therapy in eating disorder recovery: A qualitative model. *Counselling & Psychotherapy Research*, *20*(2), 248-262. https://doi.org/doi:10.1002/capr.12283

Murphy, R., Straebler, S., Basden, S., Cooper, Z., & Fairburn, C. G. (2012). Interpersonal psychotherapy for eating disorders. *Clinical Psychology & Psychotherapy*, *19*(2), 150-158.

National Institute for Health and Care Excellence (2017). Eating disorders: recognition and treatment [NICE Guideline NG69]. https://www.nice.org.uk/guidance/ng69/

NHS England. (2022, March) *NHS treating record number of young people for eating disorders.* *https://www.england.nhs.uk/2022/03/nhs-treating-record-number-of-young-people-for-eating-disorders/*

Noordenbos, G., Aliakbari, N., & Campbell, R. (2014). The relationship among critical inner voices, low self-esteem, and self-criticism in eating disorders. *Eating disorders*, *22*(4), 337-351.

Noordenbos, G., & Van Geest, Z. (2017). Self-criticism and critical voices in eating disorder patients and healthy controls. *JSM Nutritional Disorders*, *1*(1), 1003.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., & Brennan, S. E. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International journal of surgery*, *88*, 105906.

Pugh, M. (2016). The internal 'anorexic voice': a feature or fallacy of eating disorders? *Advances in Eating Disorders*, *4*(1), 75-83.

Pugh, M., & Waller, G. (2016). The anorexic voice and severity of eating pathology in anorexia nervosa. *International Journal of Eating Disorders*, *49*(6), 622-625.

Pugh, M., & Waller, G. (2017). Understanding the 'anorexic voice'in anorexia nervosa. *Clinical Psychology & Psychotherapy*, *24*(3), 670-676.

Pugh, M., Waller, G., & Esposito, M. (2018). Childhood trauma, dissociation, and the internal eating disorder 'voice'. *Child Abuse & Neglect*, *86*, 197-205.

Rieger, E., Van Buren, D. J., Bishop, M., Tanofsky-Kraff, M., Welch, R., & Wilfley, D. E. (2010). An eating disorder-specific model of interpersonal psychotherapy (IPT-ED): Causal pathways and treatment implications. *Clinical psychology review*, *30*(4), 400-410. https://doi.org/doi:10.1016/j.cpr.2010.02.001

Rycroft-Malone, J., McCormack, B., Hutchinson, A. M., DeCorby, K., Bucknall, T. K., Kent, B., Schultz, A., Snelgrove-Clarke, E., Stetler, C. B., & Titler, M. (2012). Realist synthesis: illustrating the method for implementation research. *Implementation Science*, *7*, 1-10.

Sirriyeh, R., Lawton, R., Gardner, P., & Armitage, G. (2012). Reviewing studies with diverse designs: the development and evaluation of a new tool. *Journal of evaluation in clinical practice*, *18*(4), 746-752.

Strober, M., Freeman, R., & Morrell, W. (1997). The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10–15 years in a prospective study. *International Journal of Eating Disorders*, *22*(4), 339-360.

Tantillo, M., & Sanftner, J. (2003). The relationship between perceived mutuality and bulimic symptoms, depression, and therapeutic change in group. *Eating Behaviors*, *3*(4), 349-364. https://doi.org/doi:10.1016/S1471-0153(02)00077-6

Tasca, G. A., Ritchie, K., Conrad, G., Balfour, L., Gayton, J., Lybanon, V., & Bissada, H. (2006). Attachment scales predict outcome in a randomized controlled trial of two group therapies for binge eating disorder: An aptitude by treatment interaction. *Psychotherapy Research*, *16*(1), 106-121. https://doi.org/doi:10.1080/10503300500090928

Tasca, G. A., Ritchie, K., Demidenko, N., Balfour, L., Krysanski, V., Weekes, K., Barber, A., Keating, L., & Bissada, H. (2013). Matching women with binge eating disorder to group treatment based on attachment anxiety: Outcomes and moderating effects. *Psychotherapy Research*, *23*(3), 301-314. https://doi.org/doi:10.1080/10503307.2012.717309

Tierney, S., & Fox, J. R. (2010). Living with the anorexic voice: A thematic analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(3), 243-254.

Treasure, J., Todd, G., Brolly, M., Tiller, J., Nehmed, A., & Denman, F. (1995). A pilot study of randomised trial of cognitive analytical therapy vs educational behavioral therapy for adult anorexia nervosa. *Behaviour Research and Therapy*, *33*(4), 363-367. https://doi.org/doi:10.1016/0005-7967(94)00070-Z

Wachtel, P. L. (2007). *Relational theory and the practice of psychotherapy*. Guilford Press.

Walsh, B. T., Kaplan, A. S., Attia, E., Olmsted, M., Parides, M., Carter, J. C., Pike, K. M., Devlin, M. J., Woodside, B., & Roberto, C. A. (2006). Fluoxetine after weight restoration in anorexia nervosa: a randomized controlled trial. *Jama*, *295*(22), 2605-2612.

Wilfley, D. E., Agras, W. S., Telch, C. F., Rossiter, E. M., Schneider, J. A., Cole, A. G., Sifford, L., & Raeburn, S. D. (1993). Group cognitive-behavioral therapy and group interpersonal psychotherapy for the nonpurging bulimic individual: A controlled comparison. *Journal of Consulting and Clinical Psychology*, *61*(2), 296-305. https://doi.org/doi:10.1037/0022-006X.61.2.296

Williams, K., King, J., & Fox, J. R. (2016). Sense of self and anorexia nervosa: A grounded theory. *Psychology and Psychotherapy: Theory, Research and Practice*, *89*(2), 211-228.

Williams, M. O., Tsivos, Z., Brown, S., Whitelock, N. S., & Sampson, M. (2017). Compassion-focused therapy for bulimia nervosa and bulimic presentations: A preliminary case series. *Behaviour Change*, *34*(3), 199-207. https://doi.org/doi:10.1017/bec.2017.13

Williams, S., & Reid, M. (2012). ‘It's like there are two people in my head’: A phenomenological exploration of anorexia nervosa and its relationship to the self. *Psychology & health*, *27*(7), 798-815.

Wilson, G. T., Wilfley, D. E., Agras, W. S., & Bryson, S. W. (2010). Psychological treatments of binge eating disorder. *Archives of General Psychiatry*, *67*(1), 94-101. https://doi.org/doi:10.1001/archgenpsychiatry.2009.170

**Figure 1-1.**

*Gender of Participants in All Included Articles.*

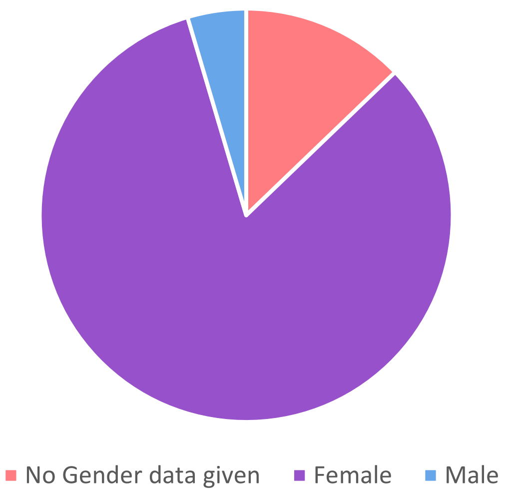


**Figure 1-2.**

*Interpersonal Interventions.*

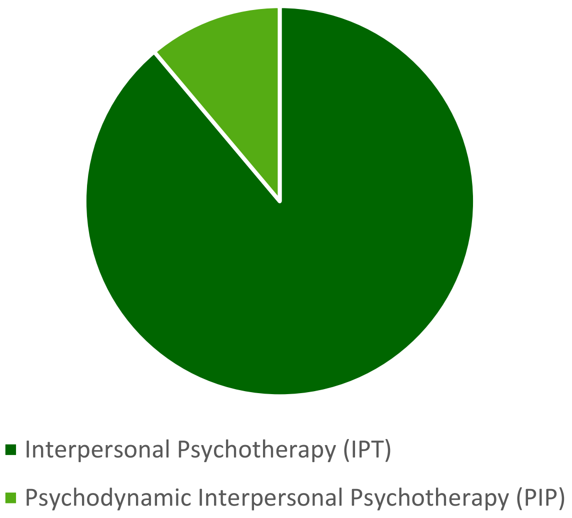


**Figure 1-3.**

*Eating Disorder Diagnoses within Interpersonal Focused Papers.*

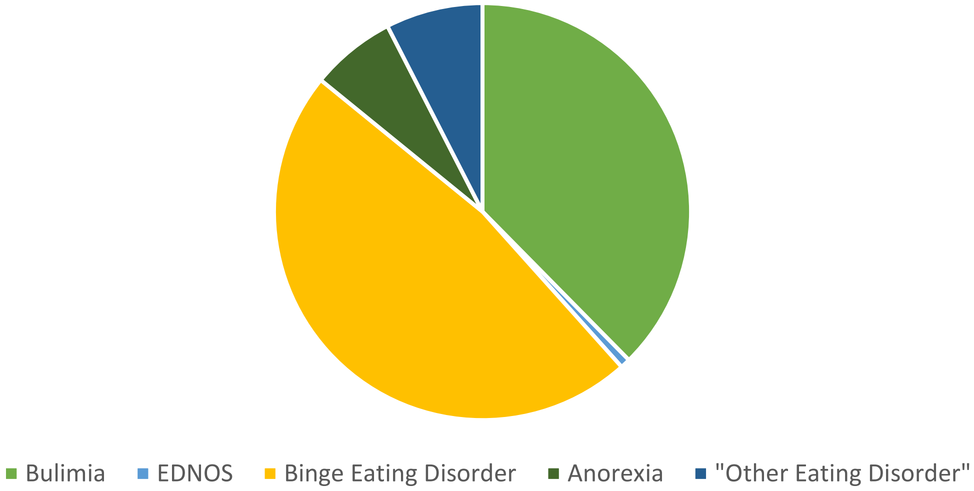


**Figure 1-4.**

*Relational Interventions.*

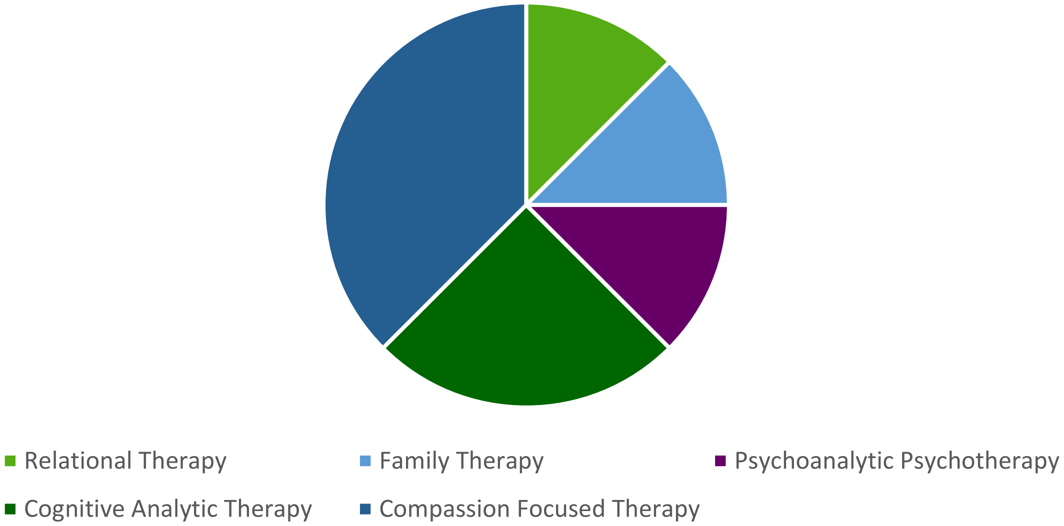
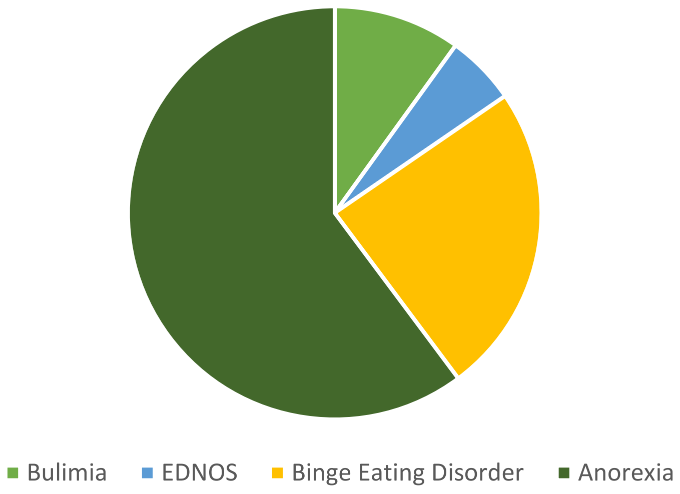


**Figure 1-5.**

*Eating Disorder Diagnoses within Relational Focused Papers.*



## Appendix 1-A

### Interventions Included within Inclusion Criteria

| Intervention Type | Included Interventions |
|---|---|
| Interpersonal | Interpersonal Psychotherapy<br>Psychodynamic Interpersonal Psychotherapy<br>Dynamic Interpersonal Therapy<br>Interpersonal Reconstructive Therapy |
| Relational | Cognitive Analytic Therapy<br>Compassion Focused Therapy<br>Voice Dialogue Therapy<br>Relational Psychotherapy<br>Feminist Relational Model<br>Relational Family Therapy<br>Family Therapy<br>Relational Therapy<br>Psychoanalytic Psychotherapy |

## Appendix 1-B

### Boolean Search Strategy

| Search Term | Label | Boolean Search Strategy |
|---|---|---|
| Eating Disorders | S1 | DE ( ( DE "Eating Disorders" OR DE "Anorexia Nervosa" OR DE "Binge Eating Disorder" OR DE "Bulimia" OR DE "Orthorexia" OR DE "Purging (Eating Disorders)" OR DE "Binge Eating" ) ) OR TI ( ( "Eating Disorder*" OR Anorex* OR ((Bing* OR purg*) N3 Disorder*) OR Bulimi* OR DE Orthorex* OR "Binge Eat*" ) ) OR AB ( ( "Eating Disorder*" OR Anorex* OR ((Bing* OR purg*) N3 Disorder*) OR Bulimi* OR DE Orthorex* OR "Binge Eat*" ) |
| Relational Interventions | S2 | TI ( ( ( ((relational OR "relational family" OR "voice dialog*" OR voice-dialog* OR voicedialog* OR "compassion focused" OR compassion-focused OR compassionfocused OR "cognitive analytic" OR cognitive-analytic OR cognitiveanalytic OR CAT) N5 (therap* OR interven* OR treatment* OR psychotherap* OR model)) ) ) ) OR AB ( ( ( ((relational OR "relational family" OR "voice dialog*" OR voice-dialog* OR voicedialog* OR "compassion focused" OR compassion-focused OR compassionfocused OR "cognitive analytic" OR cognitive-analytic OR cognitiveanalytic OR CAT) N5 (therap* OR interven* OR treatment* OR psychotherap* OR model)) ) ) |
| Interpersonal Interventions | S3 | DE "Interpersonal Psychotherapy" OR TI ( ( (Interpersonal N3 (therap* OR interven* OR treatment* OR psychotherap*)) ) ) ) OR AB ( ( (Interpersonal N3 (therap* OR interven* OR treatment* OR psychotherap*)) ) ) ) |
| Combined Search | S4 | S1 AND (S2 OR S3) |

## Appendix 1-C

### Synthesis Groupings of Selected Papers

| | Intervention Type | |
|---|---|---|
| Eating Disorder Diagnosis | Interpersonal | Relational |
| Bulimia Nervosa | Agras et al 2000<br>Bäck et al 2020<br>Chui et al 2007<br>Mitchell et al 2002<br>Jones et al 1993 | |
| Binge Eating Disorder | Hilbert et al 2015<br>Hilbert et al 2012<br>Tasca et al 2013<br>Wilson et al 2010<br>Wilfley et al 1993<br>Tasca et al 2006 | Kelly and Carter 2015<br>Tantillo and Sanftner 2003 |
| Anorexia Nervosa | Carter et al 2011<br>Mcintosh et al 2005 | Dare et al 2001<br>Treasure et al 1995 |
| Mixed Eating Disorder Diagnoses | Arcelus et al 2009<br>Arcelus et al 2012<br>Fairburn et al 2015 | Kelly et al 2017<br>Williams et al 2017 |

## Appendix 1-D

## Quality Assessment Tool for Studies with Diverse Designs (QATSDD) Scoring Grid of Included Studies

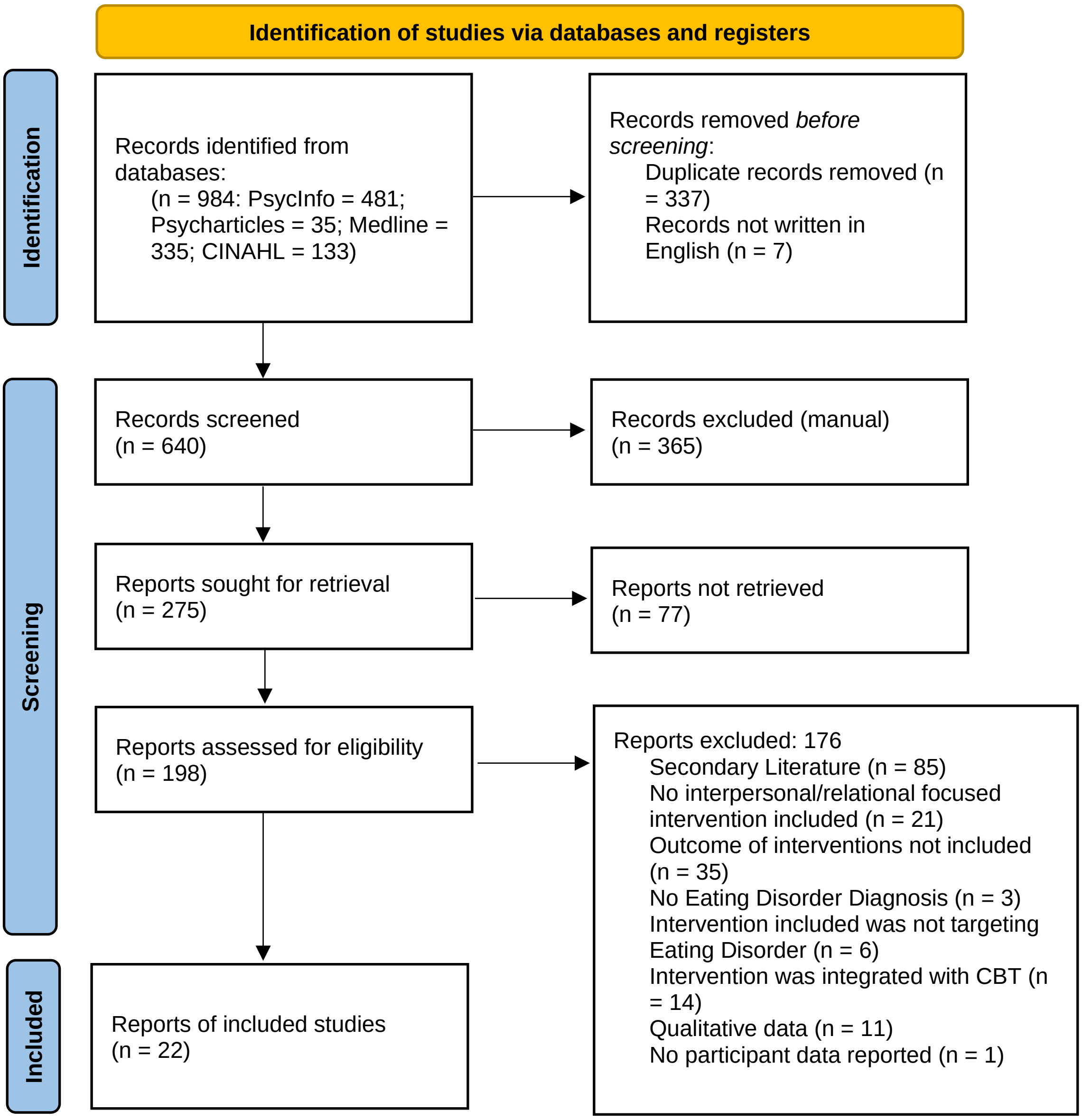
| QATSDD criteria of quality appraisal | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Explicit theoretical framework | 2 | 3 | 2 | 3 | 2 | 3 | 3 | 3 | 2 | 2 | 2 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 2 | 2 | 3 | 3 |
| Statement of research aim/s in main body of report | 3 | 3 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 3 | 3 | 2 | 3 | 3 | 3 | 3 |
| Clear description of research setting | 1 | 3 | 3 | 3 | 2 | 1 | 3 | 3 | 2 | 3 | 1 | 3 | 2 | 1 | 3 | 3 | 2 | 1 | 3 | 1 | 2 | 3 |
| Evidence of sample size considered in terms of analysis | 3 | 0 | 0 | 1 | 1 | 1 | 1 | 3 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Representative sample of target group of a reasonable size | 2 | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 0 | 2 | 0 | 1 | 2 | 1 | 0 | 1 | 2 | 2 | 2 | 2 | 1 | 2 |
| Description of procedure for data collection | 3 | 2 | 2 | 3 | 2 | 2 | 3 | 3 | 2 | 3 | 1 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 |
| Rationale for choice of data collection tool(s) | 2 | 3 | 3 | 2 | 1 | 1 | 2 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 0 | 1 | 1 | 2 |
| Detailed recruitment data | 3 | 3 | 2 | 1 | 3 | 1 | 2 | 3 | 1 | 3 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 1 | 1 | 3 |
| Statistical assessment of reliability and validity of measurement tool(s) | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 3 | 3 | 0 | 0 | 1 | 3 | 3 | 0 | 1 | 1 | 3 |
| Fit between stated research question and method of data collection | 3 | 3 | 3 | 3 | 2 | 3 | 3 | 3 | 2 | 3 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 3 |
| Fit between research question and method of analysis | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Good justification for analytical method selected | 0 | 1 | 1 | 3 | 0 | 2 | 1 | 2 | 1 | 3 | 2 | 3 | 0 | 1 | 0 | 1 | 3 | 2 | 1 | 1 | 1 | 0 |
| Evidence of user involvement in design | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Strengths and limitations critically discussed | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 1 | 3 | 2 | 3 | 2 | 2 | 2 | 3 | 3 | 2 | 1 | 1 | 2 | 2 |
| Total score (0-42) | | | | | | | | | | | | | | | | | | | | | | |
| | 27 | 29 | 30 | 29 | 21 | 24 | 28 | 32 | 19 | 33 | 19 | 35 | 28 | 21 | 23 | 28 | 36 | 29 | 21 | 20 | 22 | 32 |

*Note.* Each criteria is scored from 0 through to 3

## Appendix 1-E

## Prisma Flowchart



## Appendix 1-F

## Characteristics Table of Included Studies

| Paper Number | Authors | Date | Location | Participant Demographics | Intervention(s) | Grouping | Method(s) | Eating Disorder Measures | Key Findings | Key Recommendations | QATSDD Score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Agras et al | 2000 | USA | 220 Participants<br>Gender<br>220 - Female<br>Diagnosis:<br>220- Bulimia Nervosa<br>Average age: 28.1<br>Ethnicity:<br>77% - White<br>11% - Hispanic<br>6% - Black African and Caribbean<br>5% - Asian<br>1% - American Indian | Interpersonal Therapy or Cognitive Behavioural Therapy | Interpersonal | Random allocation to 19 sessions of either IPT or CBT and completed a follow up at 4, 8 and 12 months post-intervention | EDE-I | Participants recovered at end of treatment: CBT 29% vs IPT – 6%<br>Reduction in binge-eating: CBT – 86% vs IPT – 51%<br>Reduction in purging: CBT – 84% vs IPT – 50%<br>No significant difference between the conditions at any follow up point post-intervention as those treated with IPT show continued improvement IPT compared to slight relapses in CBT | The results demonstrate that CBT ameliorates the primary symptoms of bulimia nervosa significantly faster than IPT. However, those treated with IPT showed continued improvement at follow up. | 27 |

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| 2 | Arcelus et al | 2009 | UK | 59 Participants<br>Gender<br>59 – Female<br>Diagnoses:<br>27 - Bulimia Nervosa<br>32 - EDNOS (BN subtype)<br>Average Age:<br>28.1 | Interpersonal Therapy | Interpersonal | Case series design<br>16 sessions of IPT | EDE-Q Clinical Eating Disorders Rating Instrument | Significant reduction in overall eating disorder symptomatology, interpersonal problems, and depression.<br>No significant changes between mid-point and end of therapy suggesting effective first 8 sessions.<br>Remained significant at follow up.<br>Low self-esteem predicted a poor therapeutic outcome. | IPT is an effective treatment for individuals diagnosed with Bulimia Nervosa and EDNOS (BN Subtype).<br>Further research using a RCT design is necessary. | 29 |
| 3 | Arcelus et al | 2012 | UK | 30 Participants<br>Gender:<br>30 - Female<br>Diagnoses:<br>15 – Bulimia Nervosa<br>6 – Binge Eating Disorder<br>13 – EDNOS<br>Average Age:<br>30.5 | Brief Interpersonal Therapy, Interpersonal Therapy | Interpersonal | 3 conditions: 10 sessions of IPT-BN10, 16 sessions of IPT and wait list control group.<br>This was a case match designed with historical data. | EDE-Q Clinical Eating Disorders Rating Instrument<br>The Bulimic Investigatory Test Edinburgh | IPT-BN10 reduced eating disorders symptomology including restraint, weight, eating and shape concern, and global scores.<br>There was a reduction in self-induced vomiting but it was not significant.<br>No difference was found | Further research is needed to assess whether brief IPT is as effective as conventional 16 session IPT interventions | 30 |

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| | | | | | | | | | between typical IPT and brief IPT interventions<br>No difference in reduction of bingeing and vomiting behaviour between brief IPT and wait list control. | | |
| 4 | Bäck et al | 2020 | Sweden | 31 Participants<br>Gender<br>31 - Female<br>Diagnosis:<br>31 - Bulimia Nervosa<br>Age range:<br>19-50 | Interpersonal Therapy | Interpersonal | 12-16 sessions of IPT<br>Naturalistic design | EDE-Q<br>The Repeated Evaluation of Eating Disorder Symptoms | Significant reduction in both eating disorder symptoms from a clinical to a non-clinical level.<br>77% were remitted or improved in bulimic symptoms. | The results indicated that IPT effectively reduced symptoms in individuals with bulimia nervosa.<br>There were “early responders” within this sample however argues that due to life-long vulnerability of relapses within eating disorders a complete 16 session intervention may be more cost-effective long term.<br>Depressive symptoms should be targeted before eating disorder symptoms (a common occurring obstacle | 29 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | to Eating disorder treatment) | |
| 5 | Carter et al | 2011 | USA | 56 Participants<br>Gender<br>56 – Female<br>Diagnosis:<br>56 – Anorexia<br>Age Range:<br>17-40 | Cognitive Behavioural Therapy, Interpersonal Therapy or Specialist supportive clinical management. | Interpersonal | Random allocation to 20 sessions of CBT, IPT or SSCM. Follow up completed 5-6 years after treatment ceased. | EDE-I<br>Global Anorexia Measure<br>Eating Disorder Inventory | No significant differences between the three interventions. Those randomised to SSCM where more likely to have deteriorated to a poor outcome at follow up than those randomised to IPT. Those who received IPT had a poor global outcome rating post-treatment but improved to have the highest global outcome rating at long term follow up. CBT had a more stable course post-treatment, but IPT was not significantly slower than IPT. | A stepped approach to treatment may be advantageous as a minority of participants assessment further treatment despite having poor outcomes post-treatment. | 21 |
| 6 | Chui et al | 2007 | USA | 220 Participants<br>Gender<br>220- Female<br>Diagnosis: | Cognitive Behavioural Therapy and Interpersonal Therapy | Interpersonal | Randomly allocated to 19 sessions of either CBT or IPT | EDE-I | CBT yielded higher abstinent rates than IPT in all ethnicities. Black African-Caribbean | Future research with adequate sample sizes could investigate whether IPT is an effective | 24 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 220- bulimia nervosa<br>Average Age:<br>Ethnicity:<br>77% - White<br>11% - Hispanic<br>6% - Black African- and Caribbean<br>5% - Asian<br>0.5% - Native American | | | | | individuals responded better to IPT than CBT in reducing binge eating episodes | treatment for binge eating in black women. | |
| 7 | Dare et al | 2001 | UK | 84 participants<br>Gender<br>82 – Female<br>2 – Male<br>Diagnosis:<br>84 - Anorexia Nervosa<br>Average Age:<br>26.3 | Psychoanalytic Psychotherapy, Cognitive Analytic Therapy (CAT), family therapy or “routine treatment” | Relational | Randomly allocated to 1 year of psychoanalytic psychotherapy or family therapy or 7 months of CAT | Standardised Psychiatric Interview | Two-thirds of participants remained abnormally underweight at the end of treatment. Psychotherapy and family therapy were more effective in producing weight gain than the control treatment. CAT treatment demonstrated high levels of weight gain compared to the control treatment however this did not meet statistical significance. | It is possible to achieve improvement from anorexia nervosa using outpatient psychological treatments without resorting to hospital admission. Further research is needed for effective treatments for anorexia nervosa. | 28 |

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| | | | | | | | | | A third of participants no longer met the criteria for a diagnosis at the end of treatment | | |
| 8 | Fairburn et al | 2015 | UK | 130 participants<br>Gender<br>127 – Female<br>3 - Male<br>Diagnoses:<br>53 - Bulimia<br>8 - BED<br>69 - “Other eating disorder”<br>Average Age: 25.9<br>Ethnicity:<br>124 – White<br>1 – Black British<br>1 - Asian Chinese<br>1 – Asian British<br>3 - Multiracial | Cognitive Behavioural Therapy or Interpersonal Psychotherapy | Interpersonal | Randomly allocated to 20 weeks or CBT-E or IPT. | EDE-I<br>EDE-Q | At the end of treatment there was a reduction in eating disorder symptomology in both conditions, but two thirds of the CBT-E Group were in remission compared to the one-third of the IPT group. There was noted improvement in the IPT group at 60 weeks follow up but the difference between the groups remained statistically significant. | CBT-E is an effective treatment for the majority of adult outpatients with an eating disorder. IPT also has a broad clinical range but the response can be slower and less pronounced. | 32 |
| 9 | Hilbert et al | 2015 | USA | 205 adults<br>No gender data available<br>Diagnosis:<br>205 - Binge Eating Disorder | Interpersonal Psychotherapy, Cognitive Behavioural guided self-help and Behavioural Weight Loss | Interpersonal | Random allocation to 24 weeks of IPT, CBTgsh or BWL | EDE-I | Within the CBTgsh group there were greater rates of remission from binge-eating in rapid responders than non-rapid responders. | The results could inform a stepped approach to care with CBTgsh as a first line treatment with IPT as an alternative specialist | 19 |

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| | | | | | | | | | Rates of remission did not differ by rapid response for IPT or BWL.<br>Both rapid and non-rapid responders in the IPT condition had a greater level of remission than non-rapid responders in CBTgsh and BWL conditions.<br>Rapid responders in all conditions showed improvement in their global eating disorder psychopathology | approach for non-rapid response. | |
| 10 | Hilbert et al | 2012 | USA | 90 adults<br><br>Gender<br>71 – Female<br>19 – Male<br><br>Diagnosis<br>90 – Binge Eating Disorder<br><br>Ethnicity:<br>83 – White<br>5 – Black African<br>2 - Hispanic | Cognitive Behavioural Therapy or Interpersonal Psychotherapy | Interpersonal | Random allocation to 20 group sessions of CBT or IPT alongside 3 additional individual sessions. | EDE-I<br>EDE-Q | There were significant and long-lasting improvements for both CBT and IPT, with full recovery at a rate of 64.4%, Abstinence from binge eating was more stable in the IPT group whereas relapse rates were more significant in the CBT group. | IPT is a viable treatment alternative to the standard CBT treatment. | 33 |

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| | | | | | | | | | Improvements in Eating Disorder Psychopathology was better maintained in IPT condition whereas it worsened from the 1 year follow up to the long term follow up in the CBT condition. | | |
| 11 | Jones et al | 1993 | UK | 38 adults<br>No gender data available<br>Diagnosis:<br>38 – Bulimia Nervosa | Cognitive Behavioural Therapy, Behaviour Therapy or Interpersonal Psychotherapy | Interpersonal | Random allocation to 19 sessions of CBT, BT or IPT | Self Report – frequency of binge eating, self-induced vomiting, and laxative abuse<br>Eating Attitudes Test | All treatments improved eating behaviour of participants<br>CBT was more effective than IPT at modifying dieting, self-induced vomiting and attitudes to shape and weight.<br>Results indicate IPT has a non-specific effect as within this condition decrease in frequency of bingeing and purging ceased by week 5. However, these early effects were enduring. | Non-specific properties of psychological treatments can have an early effect on eating behaviours of those with bulimia nervosa.<br>Future research will benefit from longer periods of follow up to establish if interpersonal functioning improvements continue to be expressed. | 19 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | Kelly et al | 2017 | USA | 22 participants<br>Gender<br>21 – Female<br>1 – Male<br>Diagnosis<br>2 – Anorexia Restrictive Subtype<br>5 – Anorexia Bingeing/Purging subtype<br>4 – Bulimia<br>4 – Binge Eating Disorder<br>7 – EDNOS<br>Average Age: 31.9<br>Ethnicity:<br>22 - White | Compassion Focused Therapy and non-manualised therapy based on Cognitive Behavioural Therapy and Dialectical Behaviour Therapy | Relational | Random allocation to 12 weeks of either TAU (CBT and DBT informed) or TAU and group CFT. | EDE-Q | There were greater improvements in eating disorder pathology in participants who received CFT than TAU alone. Participants in the CFT condition fell 1 SD away from community mean norms which suggests they clinically meaningful changes in their eating disorder symptoms | Group CFT interventions are acceptable, feasible and efficacious adjunct to outpatient eating disorder treatment. | 35 |
| 13 | Kelly and Carter | 2015 | USA | 41 participants<br>Gender:<br>34 – Female<br>7 – Male<br>Diagnosis:<br>41- binge eating disorder<br>Average Age: 45<br>Ethnicity:<br>75.6% - White | Self-compassion training self-help intervention (derived from CFT) and behavioural self help | Relational | Participants were randomly assigned to 3 weeks of either Self-compassion training, behavioural self-help intervention or wait-list control condition. | EDE-Q | The self-compassion intervention significantly improved global eating disorder pathology and weight and eating concerns compared to control conditions. Participants who received self-compassion training could no | These results indicate that CFT-based interventions may be effective alongside existing evidence-based interventions for Binge Eating Disorder.<br>The behavioural self-help intervention also showed improvements and therefore a | 28 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 24.4% - Not reported | | | | | longer be identified as having an eating disorder. | combined approach may also be effective for Binge Eating Disorder. | |
| 14 | McIntosh et al | 2005 | USA | 56 participants<br>Gender<br>56- Female<br>Diagnosis<br>56 – Anorexia Nervosa<br>Age Range<br>17-40 | Cognitive Behavioural Therapy, Interpersonal Psychotherapy or Non-Specific supportive clinical management | Interpersonal | Participants were randomly assigned to 20 weeks of CBT, IPT or Non-Specific supportive clinical management conditions | EDE-I<br>Global Anorexia Nervosa Measure<br>Self report – Eating Disorder Inventory-2 | Patients who received non-specific clinical management had as good or better outcomes than those receiving CBT or IPT.<br>IPT was the least effective of the three conditions.<br>For restraint and shape concerns non-specific clinical management was superior to IPT.<br>For eating and weight concerns both non-specific supportive clinical management and CBT were superior to IPT. | A stepped approach to treatment for anorexia nervosa, with non-specific supportive clinical management as a first initial phase of treatment may be beneficial. | 21 |
| 15 | Mitchell et al | 2002 | USA | 62 adults<br>Gender<br>62 – Female<br>Diagnosis:<br>62 -Bulimia Nervosa (who | Interpersonal psychotherapy and Medication | Interpersonal | Participants were randomly allocated to either 20 sessions of IPT or Medication | EDE-I<br>Three Factor Eating Questionnaire<br>Bulimic Thought Questionnaire | There were no significant differences between medication and IPT. 24% of participants in IPT were | The findings suggested sequencing treatment this way is not recommended. | 23 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | had not responded to CBT treatment) | | | Management (Fluoxetine) | The Structured Clinical Interview | abstinent at the end of treatment compared to 19% of those prescribed medication. | | |
| 16 | Tantillo and Sanftner | 2003 | USA | 15 Participants<br>Gender:<br>15 - Female<br>Diagnoses:<br>11- bulimia nervosa<br>4 - binge eating disorder<br>Age Range:<br>20-54<br>Ethnicity:<br>15 - White | Short-term Group Relational Therapy or short-term group Cognitive Behavioural Therapy | Relational | Participants were randomly assigned to 16 weeks of either RT or CBT | Self Report – Frequency of binge eating and self-induced vomiting<br>Diagnostic Survey of Eating Disorders-Revised<br>The Eating Disorders Inventory-2 | Relational Therapy is clinically effective in reducing bulimic and depressive symptoms. There was no significant difference between RT and CBT in their overall effectiveness | Further research is needed to replicate this study with a larger sample size. | 28 |
| 17 | Tasca et al | 2006 | Canada | 135 participants<br>Gender<br>123 – Female<br>Diagnosis<br>123 – Binge Eating Disorder<br>Average Age:<br>42.75<br>Ethnicity:<br>132 – White<br>3 – Not reported | Group Cognitive Behavioural Therapy or Group Psychodynamic Interpersonal Psychotherapy | Interpersonal | Participants were randomly allocated to 16 session of either CBT or PIP or a control condition | Self Report – Frequency of Binge Eating<br>BMI<br>Three Factor Eating Questionnaire | PIP achieved similar outcomes to CBT, with both conditions resulting in greater reductions in days binged and improvements in eating disorder related attitudes than the control condition at both post-treatment and 12-month follow up. | This study provides evidence for Psychodynamic Interpersonal Psychotherapy for the treatment of binge eating disorder. | 36 |

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| | | | | | | | | | PIP also significantly reduced depression levels and improved self-esteem in participants. | | |
| 18 | Tasca et al | 2013 | Canada | 102 participants<br>Gender<br>102 – Female<br>Diagnosis<br>102 - binge eating disorder<br>Average Age: 44.26<br>Ethnicity:<br>91% - White<br>9% - Not reported | Group Psychodynamic Interpersonal Psychotherapy | Interpersonal | Participants received 16 weeks of PIP – they were allocated to groups based on whether they had low or high attachment anxiety | EDE-I<br>Three Factor Eating Questionnaire<br>Structured Clinical Interview | PIP significantly reduced days binged from pre- to post-treatment, with these changes continuing at a slower rate to the 12-month follow up. However, abstinence from binge eating in this study were lower than previous trials for PIP. | This research supports the effectiveness of PIP to reduce binge eating, depressive symptoms and eating disorder cognitions in women with Binge Eating Disorder. | 29 |
| 19 | Treasure et al | 1995 | UK | 30 participants<br>Gender<br>29 – Female<br>Diagnosis:<br>30 – Anorexia Nervosa<br>Average age<br>25 | Cognitive Analytical Therapy and Educational Behavioural Treatment | Relational | Participants were randomly allocated to 20 sessions of either CAT or Educational Behavioural Treatment | Standardised Psychiatric Interview | There were no significant differences found between CAT or EBT, however participants who received CAT self-reported improvement was greater than those who received EBT. There was no difference found between those who completed | The findings support that outpatient treatment is appropriate for older individuals with a longer history of anorexia nervosa. The lack of difference between those who completed and those who withdrew suggests shorter cases of | 21 |

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| | | | | | | | | | treatment and those who withdrew. | treatment may be appropriate for individual cases. | |
| 20 | Wilfley et al | 1993 | USA | 56 Participants<br>Gender<br>56 - Female<br>Diagnosis<br>56- non-purging bulimia<br>Average Age<br>44.3<br>Ethnicity:<br>86% - White<br>5% - Hispanic<br>5% - Black African-Caribbean<br>2% - Pacific Islander<br>2% - Indian | Group Cognitive Behavioural Therapy and Group Interpersonal Psychotherapy | Interpersonal | Participants were randomly assigned to either 15 weeks of group CBT, IPT or a wait list control condition | Self Report – frequency of Binge Eating<br>Three Factor Eating Questionnaire | Participants in both conditions demonstrated a significant reduction in the frequency of binge eating episodes compared to the control condition. At follow up – 28% abstinent in CBT condition compared to 44% in IPT and 0% abstinent in the control condition. These findings support the efficacy of group IPT. For both conditions binge eating remained significantly below baseline levels at both 6 month and 1 year follow ups. | Both treatments in this case were effective for non-purging bulimics. It is questioned whether particular types of patients would respond differently to treatments e.g. those who struggle with impulsiveness may better respond to IPT – future research to explore this. | 20 |
| 21 | Williams et al | 2017 | UK | 9 Participants<br>Gender<br>9- Female<br>Diagnoses | Compassion Focused Therapy | Relational | Retrospective evaluation of Compassion Focused Therapy | EDE-Q | Participants showed a significant decrease in eating disorder symptomatology | Future research could measure patient's self-compassion throughout treatment. | 22 |

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| | | | | 5- Bulimia Nervosa<br>4 – EDNOS<br>Average Age 29.33 | | | | | across all EDE-Q subscales following individual CFT treatment. 5 participants were in clinical remission post intervention, the remainder still showed a marked decrease in their eating disorder symptoms. | Additional research is needed to confirm CFT's effectiveness as an intervention for eating disorders e.g. randomised control trials but these preliminary results are promising. | |
| 22 | | Wilson et al | 2010 | USA | 205 participants<br>Gender<br>162 – Female<br>43 – Male<br>Diagnosis<br>205 – Binge Eating Disorder<br>Average Age 48.4<br>Ethnicity<br>82% - White<br>0.3% - American Indian<br>13% - Black African-, Asian-, Caribbean<br>4.7% - Hispanic | Interpersonal Psychotherapy, Behavioural Weight Loss Treatment and Cognitive Behavioural Therapy (guided self-help) | Interpersonal | Participants were randomly allocated to 20 sessions of IPT or BWL, or 10 sessions of CBTgsh. Follow ups were completed for 2 years following treatment cessation. | EDE-I | There were no significant differences between the three interventions at post treatment on binge eating frequency. However, at the 2 year follow up IPT and CBTgsh were significantly more effective than BWL in eliminating binge eating. Attrition rate was lowest in IPT condition compared to the others. | Due to CBTgsh and IPT demonstrating similar results in the reduction of binge eating at 2 year follow up, CBTgsh could be considered as a first line of treatment with IPT as a more in-depth treatment. IPT was also shown to be effective with individuals with low self-esteem and high level of specific eating disorder psychopathology. | 32 |

## Appendix 1-G

## Author Guidelines for European Eating Disorders Review Journal

# *European Eating Disorders Review* Author Guidelines

### 1. SUBMISSION

New submissions should be made via the Research Exchange submission portal https://wiley.atyponrex.com/journal/ERV. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at anytime by logging on to submission.wiley.com and clicking the “My Submissions” button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

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### 2. AIMS AND SCOPE

*European Eating Disorders Review* provides an international forum for disseminating cutting-edge theoretical and empirical research that significantly advances understanding of the relationship between Eating Disorders and Abnormal Eating/Weight conditions and well-being in humans.

*European Eating Disorders Review* publishes authoritative and accessible articles, from all over the world, which review or report original research that has implications for the treatment and care of people with eating disorders and obesity, and articles which report innovations and experience in the clinical management of eating disorders. The journal focuses on implications for best practice in diagnosis and treatment. The journal also provides a forum for discussion of the causes and prevention of eating disorders, and related health policy.

Authors may submit original theoretical systematic reviews, methodological, or empirical research articles (5000 words or less) brief reports (2,500 words or less) and commentaries (2,000 words or less). The journal also publishes invited conceptual reviews from leading worldwide researchers in the field of Eating Disorders and/or Obesity. The aims of the journal are to offer a channel of communication between researchers, practitioners, administrators and policymakers who need to report and understand developments in the field of eating disorders.

**The journal**

- Reports on useful research and experience related to the treatment and prevention of eating disorders in primary care and hospital settings, with special attention to therapy oriented translational research, high quality reviews, clinical trials and pilot innovative therapy approaches.
- Provides information about 'good practice' and systematic reviews.
- Offers a forum for new thinking about the nature, incidence, diagnosis and clinical management of eating disorders (namely anorexia nervosa, bulimia nervosa, binge eating disorders, OSFED and other abnormal eating or feeding behaviors associated with childhood and obesity.

## 3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

**Research articles** reporting new research of relevance as set out in the aims and scope should not normally exceed 5000 words (excluding abstract, references, tables or figures), with no more than five tables or illustrations. They should conform to the conventional layout: title page, Abstract, Introduction and Aims, Method, Results, Discussion, Acknowledgements and References. Each of these elements should start on a new page.
Word Limit: 5,000 (excluding abstract, references, tables or figures).
Abstract: 200 words, structured
References: up to 60.

**Review articles:** Systematic and meta-analytic review papers are welcomed if they critically review the available literature in a topic than will enhance clinical practice. Articles should have clear focus and enough number of studies should be available for a substantive review paper. Studies that only describe or list previous studies without a critical overview of the literature will not be considered.

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Abstract: 200 words.
References: up to 100.
Figures/Tables: 5 maximum, but should be appropriate to the material covered. Additional tables might be included as supplementary information, if needed. Review articles must follow the PRISMA Guidelines. Authors may want to have a look at the review check lists that reviewers when assessing review articles.

**Brief reports** should concisely present the essential findings of the author's work and be compromised of the following sections: Abstract, Introduction and Aims, Method, Results, Discussion, and References. Tables and/or figures should be kept to a minimum, in number and size, and only deal with key findings. In some cases authors may be asked to prepare a version of the manuscript with extra material to be included in the online version of the review (as supplementary files). Submissions in this category should not normally exceed 2500 words in length.

Brief reports bring with them a whole host of benefits including: quick and easy submission, administration centralised and reduced and significant decrease in peer review times, first publication priority (this type of manuscript will be published in the next available issue of the journal).

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- The title page of the manuscript, including:
    - Your co-author details, including affiliation and email address.
    - Statements relating to our ethics and integrity policies, which may include any of the following:
        - data availability statement
        - funding statement
        - conflict of interest disclosure
        - ethics approval statement
        - patient consent statement
        - permission to reproduce material from other sources
        - clinical trial registration

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### ***Graphical TOC/Abstract***

The journal’s table of contents/abstract will be presented in graphical form with a brief abstract.
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The image supplied should fit within the dimensions of 50mm x 60mm and be fully legible at this size.

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# Section Two: Empirical Research Paper

# Exploring Experiences of Emerging Multiplicity and Voice Personification in the Context of an Eating Disorder with Young Women

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Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Prepared in accordance with author guidance for *Child and Adolescent Mental Health*

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## Abstract

**Background:** The prevalence of eating disorders (ED) for young people, particularly young women, is a global concern, with maintaining factors including low self-esteem, body dissatisfaction and societal idealisation of thinness. One maintaining factor gaining research attention is, the Eating Disorder Voice (EDV), which affects 94.5% of the ED population. The EDV is an auditory experience that comments on the individual's body shape, weight, and eating behaviours. It can actively undermine ED treatment, such as talking therapy, yet mechanisms to address the EDV in treatment are currently unknown. Research has queried the EDV's position on the voice-hearing continuum as it can resemble auditory hallucinations. However, evidence also indicates that other multisensory experiences, such as multiplicity and voice personification, could share phenomenological similarities with the EDV. There is no existing literature that explores the relationship between these multisensory or multi-self experiences. The current qualitative study aimed to collaboratively explore voice personification and the *self*, alongside the EDV, with young women experiencing an ED to enhance our understanding of this under-researched but common phenomenological aspect of EDs.

**Method:** An adapted Experience-Based Co-Design (EBCD) methodology was implemented to create a three-layered data collection process. In layer one, participants submitted their story of living with an EDV. In layer two, further stories were gathered within a group discussion. In layer three, emerging narratives from initial analysis of these stories were presented within a group discussion to obtain participant's feedback on the interpretation of their stories. Overall, lived experience stories were heard from 11 female identifying participants aged 20-24-years-old. The three data layers were analysed collectively using a Narrative Analysis framework.

**Results:** Emancipatory narrative layers were organised into three chapters: (1) A Continuum of the EDV experiences, (2) Conflict between the Self and the EDV, and (3) The role of an EDV in the maintenance of an ED. The results highlighted a continuum of EDV experiences, including voice personification and the embodiment of an EDV within a system of multiple selves, and that the complex relationship with the EDV maintains an ED which stresses the importance of addressing this relationship within treatment to aid recovery.

**Conclusions:** Future research should aim to develop effective interventions to address the individual's relationship with the EDV and their loss of sense of self. Furthermore, implementing an EBCD service development within an ED service could advance interventions while including the unrepresented multiplicity community.

## Key Practitioner Message

- The position of the EDV on the voice-hearing continuum, in relation to other multisensory and multi-self experiences, has been queried.
- The EDV is experienced along a continuum from a voice or presence that becomes human-like to a member within a system of multiple selves.
- The complex relationship between the individual and their EDV maintains their eating disorder and therefore should be addressed within interventions.
- Further collaboration through experience-based co-design methodologies is necessary to represent the unheard multiplicity population within this field.

*Key Words: eating disorders, eating disorder voice, multiplicity, voice personification, experience-based co-design*

## Introduction

Eating disorders (ED) are a global concern impacting the physical and mental health of the population. In western cultures, 5.5-17.9% of young women and 0.6-2.4% of young men have experienced an ED by early adulthood, with similar prevalence rates in Asia, Eastern Europe, Latin America, and developing countries (Lyons, 2017; Silén & Keski-Rahkonen, 2022). Compared to cisgender individuals, transgender and gender-diverse populations are 2-4 times more likely to develop ED symptoms (Gordon et al., 2021), with a higher prevalence reported in transgender men than transgender women (Diemer et al., 2018; Simone et al., 2022). The term ED encapsulates the diagnostic categories of anorexia nervosa, bulimia nervosa, binge eating disorder and Other Specified Feeding and Eating Disorders (American Psychiatric Association, 2013). These diagnoses include the presence of negative beliefs about the body, eating, and weight, which the individual attempts to manage through ED behaviours, such as restricted eating, binge eating, and compensatory purging behaviours (National Institute for Health and Care Excellence [NICE], 2017).

Risk factors potentially contributing to high prevalence rates in adolescence include: early traumatic events (Solmi et al., 2020); low self-esteem (Colmsee et al., 2021); self-disgust (Bektas et al., 2022); body dissatisfaction (Rohde et al., 2015); and idealisation of thinness (Keel & Forney, 2013). Additionally, the COVID-19 pandemic may have been a catalyst for increasing ED thoughts and behaviours as an attempt to tolerate heightened anxiety (Phillipou et al., 2020; Scharmer et al., 2020), perhaps explaining the 25% increase of young people accessing ED treatment from 2021 to 2022 (NHS England, 2022). Understanding and effectively treating EDs is therefore an increasing clinical priority.

Alongside establishing the aetiology of EDs, research is exploring potential maintaining factors of ED behaviours. This includes a voice-hearing phenomena coined the Eating Disorder Voice (EDV), experienced by 94.5% of the ED population (Noordenbos et al., 2014). Although not an omnipresent experience, the EDV is typically an internally generated voice that creates an interdependent relationship by promising solutions to the person's problems, involving criticism and rules regarding the individual's body, weight, and eating habits (Burnett-Stuart, 2021; Noordenbos et al., 2014; Pugh, 2016). Individuals describe a shifting relationship with the EDV, initially perceiving it as a comforting friend then, as the ED endures, a controlling entity. Accounts compare their EDV to an abusive partner, that causes them to feel entrapped and helpless (Noordenbos & Van Geest, 2017; Tierney & Fox, 2010; Williams et al., 2016; Williams & Reid, 2012). Furthermore, the frequency and power of the EDV positively correlate with the ED severity as the EDV demands the individual engages in ED behaviours (Marffy et al., 2023; Noordenbos et al., 2014; Pugh & Waller, 2016). As the EDV contributes to maintaining the ED, including negative beliefs about the body, eating, and weight and subsequent compensatory behaviours (Pugh & Waller, 2017), research attention is required to inform intervention development.

Existing research has focused on establishing the EDV's position on the voice-hearing continuum (Baumeister et al., 2017), which demonstrates the spectrum of voice-hearing experiences from sub-clinical populations to populations with pronounced clinical difficulties. Although the EDV shares features with pseudo-hallucinations, like being an internally based experience (Pugh & Waller, 2017), research argues the EDV's position on this continuum shifts between inner speech and auditory hallucinations (Pugh, 2016; Pugh et al., 2018). Prior to this study, a narrative review demonstrated that the voice-hearing continuum may be more interconnected than a distinct linear spectrum and that multisensory experiences, such as Multiplicity and Voice Personification, are difficult to distinguish within adolescents and may be occurring simultaneously. It is therefore possible that these multisensory experiences interact with other experiences within the continuum such as the EDV phenomena.

## Multiplicity

Multiplicity is the sub-clinical experience of being more than one self, person, or identity (Young Voices Study, 2021); a system comprising of multiple selves, known as "headmates" or “alters” that share one body (Ribáry et al., 2017; Spanos, 1994). Each self may have distinct characteristics including, age, gender, thoughts and feelings; with typically one ‘self’ fronting the system, assuming control of the mind and body, at a time (Ribáry et al., 2017). Figure 1 extracted from Parry et al. (2021) contextualises multiplicity in relation to other multisensory experiences in adolescents demonstrating the interconnected nature of voice-hearing experiences and the need for further concurrent exploration of multi-sensory and multi-self experiences.

[INSERT FIGURE 1]

Multiplicity may develop as a coping mechanism to protect the individual from an inescapable danger, causing an inability to tolerate staying in the present (Sar, 2011; Simeon et al., 2023). There is a heterogeneity of dissociative experiences. Dissociative Identity Disorder (DID) characterised as having “two or more distinct personality states”, occurs alongside clinically significant symptoms such as amnesia of events, distress, or impaired functioning (Reinders & Veltman, 2021). Multiplicity is not a diagnosis and instead is a sub-clinical experience of being a system of multiple selves as it does not cause distress. However, a lack of clinical understanding means multiplicity is frequently misdiagnosed as DID (Coons, 1998; Wang et al., 2002), which can be an invalidating experience (Parry et al., 2021). Furthermore, the intended treatment outcome of psychological support for DID aims to integrate the system members into an undifferentiated “whole self”.  The multiplicity community argue this approach attempts to silence and “fix”, instead of promoting communication within the system (Eve & Parry, 2021; Rothschild, 2009). Multiplicity should therefore be supported as distinct from a DID diagnosis.

Shared phenomenological features are common within the voice-hearing continuum, with multiplicity sharing similarities with the EDV phenomena. Previous accounts have described the EDV as a bulimic or anorexic “sub-self” with its own distinct needs, feelings and behaviours separate to the individual’s self (Pugh, 2020; Sands, 1991). Therefore, further exploration is needed to understand the relationship between these seemingly distinct multisensory experiences.

## Voice Personification

Voice personification is a voice-hearing experience where the voice becomes person-like but separate to the person's self (Alderson-Day et al., 2021; Chadwick et al., 1996), and personification of the voice can manifest on a continuum of experiences (Collins et al., 2023). The voice may display minimal identifiable characteristics, such as gender or age, or exhibit complex characteristics that vary over time, including identity and intentional states (Alderson-Day et al., 2021). Furthermore, the voice may be internally or externally individualised (Wilkinson & Bell, 2016). Internally individualised voices cannot be attributed to a pre-existing identity and instead are identified by specific characteristics e.g., a young boy's voice. Alternatively, externally individualised voices are recognisable to the individual, such as a friend or relative (Beavan, 2011), or the individual's own self at a particular age when a traumatic life event potentially occurred (Corstens & Longden, 2013).

Trauma is the dominant contributing factor in research examining the aetiology of the voice-hearing continuum, including voice personification (Corstens & Longden, 2013; Spikol & Murphy, 2019), multiplicity (McRae et al., 2017; Parry et al., 2018) and the EDV (Kent & Waller, 2000; Pugh et al., 2018), with trauma shown to impact ED treatment outcomes (Day et al., 2023). Therefore, demonstrating that these voice-hearing experiences share phenomenological similarities. By studying the experiences of living with an EDV as a distinct self or a personified voice-hearing experience, we may better understand whether tailored treatment pathways for each presentation are necessary to effectively address the EDV through psychological interventions.

## Aims and Objectives

As up to 17.9% of young women are affected by EDs (Silén & Keski-Rahkonen, 2022), it is important their experiences are heard to accurately understand these multisensory experiences. This research gathered young women's stories through a qualitative methodology which allowed participants to tell their stories through a medium of their choice e.g., written piece, poetry, or artwork. To ensure this research was led by lived experience rather than protocol, an Experience-

Based Co-Design (EBCD) informed methodology (Point of Care Foundation, n.d.) was implemented. This allowed a common language framework to be developed with participants and ensured a collaborative, validating procedure for young women to share their experiences in a supportive environment that appropriately represents them (Haines et al., 2019). This qualitative research study aimed to explore how multiplicity and voice personification are experienced by young women living with an ED voice, self, or part. This is the first research study to examine these seemingly distinct multisensory experiences simultaneously.

## Methods

### Design

This qualitative research implemented an informed EBCD methodology (Point of Care Foundation, n.d.). This approach, commonly used in service design, combines expertise from people with lived experience to aid collaboration, understanding, and service improvements (Point of Care Foundation, n.d). Recently, this approach has been effectively adapted for research methodologies (Raynor et al., 2020; Flyan et al., 2021; Girling et al., 2022), with benefits including reaching marginalised populations, creating an equal partnership between participants and researchers, and a wider impact of research (Gustavsson & Andersson, 2019). This research project utilised the principles of EBCD, including storytelling and empowerment, to facilitate the co-design of knowledge of multisensory experiences and the EDV in young women.

The traditional stages of EBCD are outlined in Appendix A. Due to the stage of the research and research question, the implemented EBCD approach did not involve health care service staff nor dedicated service development stages. Accordingly, an EBCD informed layered data collection approach was designed (see figure 2.) to include reflective discussions with participants interwoven throughout the data analysis to represent their stories.

[INSERT FIGURE 2]

## Materials

### *Layer one – original stories from first person experiences*

A Qualtrics questionnaire was used to obtain consent, demographics information (such as gender, age, ethnicity, location and duration of their ED, voice-hearing and multisensory experiences), and the participant's story.

### *Layer two – online reflective discussion and graphic illustration of reflections*

A Qualtrics questionnaire was used to obtain basic demographic information and consent to attend the online group discussions.

A Zoom Pro account held by an external facilitator Fiona Malpass, a project manager from the UK-based charity Voice Collective, was used to host the online group.

### *Layer three – online feedback discussion of multisensory experiences and the EDV*

A Qualtrics Questionnaire was used to obtain basic demographic information and consent to attend the final group discussion.

The online group was held via Microsoft Teams due to facilitators not possessing a Zoom Pro account.

## Participants and Recruitment

Ethical approval was given by Lancaster University Faculty of Health and Medicine's Research Ethics Committee (FHMREC reference: FHM-2022-0942-RECR-2). Full documentation of the ethics application can be found in section four.

Participants were primarily recruited by advertisements on social media and the Lancaster University's Campus. Additional recruitment methods included advertising on the research page of Beat's website, the UK's leading ED charity, and an episode on the "Love This Food Thing" podcast.

The inclusion criteria for participation was self-identifying as a female (either the host, or the headmate/alter who experiences the ED behaviours identifies as female), aged between 16-25-years-old, current or previous experience of voice-hearing or another multisensory experience, and self-identify as current or previous experience of an ED. Prospective participants who did not meet these criteria were excluded.

In total, 11 participants were involved in this research (see table 1.). Of the initial 10 participants involved in layer 1, 3 continued their participation in layer 2. The participants within layer 3 comprised of 1 original retained participant and 1 who only partook in layer 3 (see figure 2.). Each participant was given an alias to maintain confidentiality.

[INSERT TABLE 1]

### *Layer one – original stories from first person experiences*

Within this layer, the sample consisted of 10 females aged 20-24-years-old. The majority were White British (60%) and based in the UK (60%). The mean duration of the participants' EDs was 6.4 years, voice-hearing experiences was 5 years, and multisensory experiences was 1.9 years.

### *Layer two – online reflective discussion and graphic illustration of reflections*

The sample within layer two consisted of three females aged 20-22-years-old, who were retained from layer one. The majority were White British (66.67%) and based in the UK (66.67%). The mean duration of the participants' EDs was 6.6 years, voice-hearing experiences was 8 years, and multisensory experiences was 2 years.

### *Layer three – online feedback discussion of multisensory experiences and the EDV*

The sample within layer three consisted of 2 females who were both 21-years-old. The ethnicity of the participants was White British (50%) and Caucasian-Asian (50%). Participants were based in the UK (50%) and Canada (50%). One participant was retained from layer two and a further participant was recruited via social media.

## Data Collection

During the layered data collection, participants were selectively invited to the final online discussion to ensure the sample effectively answered the research question. The retention and attrition rates are reported in Figure 3.

[INSERT FIGURE 3]

Layers one and two of the data collection were completed alongside another Trainee Clinical Psychologist to efficiently use participant’s time and reduce potential recruitment challenges. The data collected in these layers underwent an initial analysis, completed independently, to identify emerging narratives that informed discussions during the final layer of data collection.

### *Layer one*

Participants were invited to submit their story of voice-hearing, multisensory experiences and living with an ED. Participants were given the choice on how to tell their story e.g. written piece, poem, or artwork, which provides rich data of their experiences that may not have been captured within semi-structured interviews. These stories were submitted on Qualtrics, where participants could express interest in participating in later layers of the research.

### *Layer two*

Participants attended an online group, held in July 2023 for two hours via Zoom and co-facilitated with Fiona Malpass, to discuss their experience of voice-hearing, multisensory experiences, and living with an ED. A live illustrator, Emma Paxton, attended the webinar to visually capture the group discussions (See Appendix B) which provided an infographic representation of participant’s stories that cannot be achieved through other qualitative methodologies. Participants were invited to participate in the final layer of the research.

### *Layer three*

Participants attended an online group, held in October 2023 for two hours via Microsoft Teams, to share the relationship between their experience of multiplicity and voice personification alongside an EDV. Initial emerging narratives from the data compiled from layer one and two were presented within the group. Participants provided reflections on the presented narratives and whether they felt it accurately represented their own experiences.

Within the online groups, breaks were scheduled at the mid-point of the reflective discussion. Participants were encouraged to take any necessary breaks for their wellbeing, and there was a dedicated facilitator present to offer individual support outside of the group. Each session concluded with a group check-out and debrief with participants including information of additional support services available. Facilitators engaged in a team debrief after each online group.

## Data Analysis

The epistemological standpoint of the researcher, critical constructivism (Kinchelow, 2005), was considered when deciding the analytic process of the research. Critical constructivists support the idea that knowledge is constructed within our minds, which are further constructed by the surrounding society (Geelan, 1996; Kinchelow, 2005). Narrative Analysis was therefore implemented to allow for the co-construction of a narrative between the speaker and listener while accounting for social construction of that story (Esin et al., 2014). Unlike other qualitative analytic approaches, which divides data into “codes”, Narrative Analysis keeps participant’s stories whole to preserve and observe the details within. These narrative blocks are compared to generate core narratives (Smith, 2016). As stated by Gibbs (2007), this approach “adds a new dimension to qualitative research. It focuses not just on what people said and the things and the events they describe but how they said it, why they said it and what they felt and experienced.” (p.71)

Prior to commencing data collection, a narrative framework was developed by compiling several narrative methods to guide the analysis and provided transparency in the process (See Appendix C). The framework accounted for the potential different multimodal data (visual, audio or text-based) within layer one. For visual data, analysis involved familiarisation with the data, categorising based on the research question, producing detailed summaries of the categorised data, and developing overarching layers of meaning based on the whole visual data set (Collier, 2001). For text-based data, following familiarisation, important concepts including narrative tone, imagery, and themes were identified (Crossley, 2007). The framework also considered elements of structural narrative analysis, like tonality, pace and language (James, 2023), functional narrative analysis, like the narrative content and structure (Atlas.ti, n.d), and socio-cultural themes that shaped their story. Audio data was transcribed and the text-based data analysis stages followed. A summary story was created for each participant to ensure the final narrative captured their story's key touchpoints. These stories were subsequently woven together to form a coherent story and overarching narratives were identified and organised into chapters.

Following data collection layer one and two, steps 1-3 of the narrative analysis framework were completed on the initial data to inform themes for the online discussion during layer three. Upon completion of data collection, narrative analysis was then completed in full (See Appendix D). The structural and functional components of the narratives, how the participants told their stories and why, were the dominant elements that formed the chapters.

## Findings

The findings represent a shared narrative that emerged from the data organised into chapters. Chapter One represents the continuum of experiencing the EDV. Chapter Two describes the relational conflict between the individual and their EDV. Finally, Chapter Three explores how the EDV maintains the ED behaviours and its impact on participants journey of recovery.

### *Chapter One: A Continuum of the EDV Experiences – "A parasite in your brain that is both your worst enemy and very best friend" (Anne)*

This chapter outlines three core narratives which each represent a continuum on which participants experience the EDV; the EDV on the Continuum of Multisensory and Multi-self Experiences, the EDV and Me, and the Relationship with the EDV.

## The EDV on the Continuum of Multisensory and Multi-self Experiences

Participants experienced the EDV along the continuum of voice-hearing (see Appendix E), with some descriptions highlighting their EDV experiences shifting between those points. For some, their EDV mirrors an auditory hallucination where “it doesn’t have a voice it’s kind of a collection of [Karen’s] own thoughts…it doesn’t sound like [her] own voice or anyone else’s”. The language use demonstrated the EDV as a voice but without any distinct features or characteristics, as Karen has “never been able to imagine it’s a person or give it a name”.

However, later in her story, Karen stated, “it’s quite scary that it is something in my brain like it feels like an actual person the amount of sneakiness that goes into the way that it is” and described her EDV as a “bitchy little self”. Her account demonstrates the fluidity of the EDV and how it can move towards a voice personification experience. Evidence of voice personification is noted by the use of pronouns: “she”; “they”; “he”. In some stories, personification of their EDVs was stronger. The EDVs Anne experienced were called “Adam” or “The Scientists” and had intentional actions as “if it has a mind of its own”. Furthermore, Max’s language references Kate Moss’ 2009 quote “nothing tastes as good as skinny feels” when they express that “She doesn’t care. She only knows. Skinny tastes better than everything” (Max). Participants’ use of such phrases demonstrates an internalisation and personification of diet culture and media influence. Therefore, it is evident that the personification of the EDV can vary along a continuum from simple to complex personification.

Two participants connected their EDV to their experience of Multiplicity. Claire expressed that it “got isolated out into a single person within the system”, while Triss describes “an internal experience that is connected to me”. Within Claire’s story, they described that “most of us honestly don’t have involvement with any symptoms of ED”, with only the host and one alter experience symptoms. Yet, the power held by the EDV within their alter was experienced physically. They described their alter doing “a special kind of switching…catch[ing] whomever fronting off guard and rush[ing] them from behind, tackling them and running them over straight towards front with no communication”. The language used demonstrates the powerlessness over the alter when triggered. Claire’s narrative also expressed that their system’s “ED recovery is much closer to supporting a family member with an addiction than a singlet recovering from their own ED”, highlighting the differences between EDV experiences along the continuum.

Although not all participants experienced multiplicity, the experience of feeling “dissociated from real life” (Karen) and “not fully present” (Anne) featured within other participants’ stories.

### The EDV and Me

The language used by participants highlighted another continuum the experience of EDV may lie on – an internal to external experience.

Those who experienced the EDV as internal described a physical connection to the voice as an “anorexic voice in my head” (Brianna) or “living rent free in my mind” (Karen). These language choices represent the EDV as an unwanted guest who has settled inside their mind. Meanwhile, others attributed their EDV to an external agent which was distinct and separate to themselves, describing a “demon” (Anne), “a pet they tolerate” (Claire), and “a starry red fox monster” (Claire). In Claire’s narrative, the alter experiencing the EDV becomes unrecognisable to the system when triggered. A common image used by participants was calling the EDV “a parasite in your brain that is both your worst enemy and very best friend” (Anne). This holds connotations of the EDV infiltrating their mind and suggests the immediate lack of control participants felt when their EDV manifested.

Within the online discussions, Anne reflected that the EDV initially felt like an internal experience. She expressed that “when they said you’ve got to fight it”, she questioned if they were asking her to fight “like myself?... rather than the other thing that they were able to see was like a parasite on me”. However, in recovery, her viewpoint shifted to an external experience. She “could see now how it is like you’re fighting against some sort of illness like a parasite but at the time I think I found it quite difficult to see it that way”. This demonstrates the fluidity of the EDV on this continuum throughout an individual's journey. Furthermore, Madi describes her experience as both "a shadow that lives in my brain" and "someone talking over my shoulder", suggesting that the presence of an EDV can be felt simultaneously as internal and external.

### The Relationship with the EDV

Prominent in participants' stories was their relationship with their EDV. The narratives demonstrated that these relationships could be mapped onto a continuum from negative to positive.

One participant, Karen, had "never experienced it [EDV] in a positive way" as it "was never my friend". The language used by participants suggest the voice is "overpowering" and they "have no control over it" (Triss) or "felt controlled by it…to obey its orders" (Jenny). One resonating narrative was comparing their relationship with the EDV to how "an abusive partner will…try and isolate you from people that would keep you safe and be like your safety net", stating "it's like an eating disorder does that as well" (Anne). This imagery provides the listener with insight into the motives and actions of the EDV which ensures the individual is reliant on it.

However, there was also evidence of a compassionate relationship within participants' narratives. In her poem, Max states "isn't it healthy, no it's not baby". This structure seems to mimic a conversation with the EDV where it is seeking reassurance or praise from Max and her response is compassionate as if talking to a younger version of herself. Similarly, although Karen states they have not experienced the voice positively, a touchpoint in her narrative was that the EDV "saved my life", implying a positive relationship.

A common feature within participants' narratives was an "ever changing" (Claire) relationship with the EDV which could be "described differently throughout its different stages" (Anne). For example, the compassionate relationship in Max's poem is contrasted by the language "it's a problem". Furthermore, Anne's reiteration of the abusive partner metaphor demonstrates a changing relationship when it can "seem positive at first and it can seem protective and helpful and even like a confidence boost… like an abusive partner will try and love bomb at first…and get you hooked on them" (Anne). For Claire, this relationship was context dependent as the EDV was a member of their internal system. They describe the alter as "a pet they tolerate" but also feel appreciation that "my system has taken extra care of me". Within the system, each member has a different relationship with the alter experiencing the EDV. This conflict is demonstrated when Claire reflects that she "love[s] him and any effort to support him… is worth it" but that the "other alters find it annoying, stress inducing or like [he] may be a burden on us, one more symptom to manage in a complicated situation". The participant's relationships with their EDV, like any social relation, may therefore change frequently.

Despite being outlined separately, these continuums should be thought of as interconnected to demonstrate the varied spectrum of EDV experiences. Figure 3 illustrates a schematic representation of the three axis that participants' experiences may be mapped along. For instance, a personified EDV that is perceived as negative and external to the individual would be positioned differently on the continuum to an EDV considered a distinct member within an internal system that fosters a positive relationship.

[INSERT FIGURE 4]

*Chapter Two: Conflict between the self and the EDV – "Its will became mine" (Anne)*

This chapter explores conflict, a key character in participants' stories, and is separated into two core narratives – Conflict in Identity and Conflict in Recovery.

**Conflict in Identity**

A touchpoint for the majority of participants was the impact of struggling to separate their identity from their EDV. For example, there was evidence of pronouns changing from "he" to "I feel I am the EDV" (Claire). Claire described their alter as "a personification of that voice" with the alter feeling that "the voice comes from within themselves yet without much separation from the EDV". Lacking separation from the self was reflected when Anne stated "its will became mine" and when Karen reflected that "without an ED, I don't know who I am", stating that it was "really easy to recognise…at the beginning", "like two balls of wool that were tangled up together". She describes that her "brain was…red and the ED was black so you could really distinguish between my thoughts and the EDV", expressing that "the longer that I've had the ED, the more entwined it's…become" so "now it's like my brain and the EDV are like two different shades of red, so you can barely tell them apart", therefore demonstrating loss of identity as an ED progresses.

Referencing the aforementioned continuum from an internal to external EDV experience, participants' conflicting identities demonstrate the impact that experiencing the EDV as an entity connected to oneself can have on not only a sense of self but also on recovery.

### Conflict in Recovery

In recovery, participants referenced a common metaphor used in ED services: the need to "fight the eating disorder". Yet, some participants found this metaphor difficult to relate to due to the interconnection of their identity and the EDV, feeling as though they are "fighting against [their] own voice" (Karen). One participant described feeling like "I'm protecting one part of my body" (Triss), therefore demonstrating how identity can cause further conflict within recovery.

The relationship with the EDV also contributed to participants feeling conflicted about their recovery journey. There was a shared sense that recovery would result in a loss of that relationship, regardless of the nature of the relationship with the EDV. The language used by participants compared recovery to "a loss like a break up", feeling "lost without him" "even though he was so bad for me" (Anne). This is echoed when Karen states "it feels like breaking up with someone but breaking up with yourself". Karen's sense of identity alongside her EDV contributed to a conflicted narrative of recovery. She described being "scared to let go" as recovery would result in losing "a piece of my puzzle, a piece of my life, and a piece of me". Although Claire also equated recovery to experiencing loss, recovering from an ED in the context of their multiplicity meant accepting that "there will never be a fix without taking away our loved one" and this resulted in conflicting feelings towards recovery as it is "hard to let go because it's one of us". Therefore, difficulties surrounding a sense of self and a loss of a relationship with the EDV are key in participants' journey with recovery.

## *Chapter Three: The Role of an EDV in the maintenance of an Eating Disorder – "Despite having fallen down that hole too many times" (Anne)*

This chapter explores how the EDV maintains the participant's ED. Three core narratives are described – The Power of the EDV, Trapped in a Cycle by the EDV, and Barriers to Accessing Support for Multiplicity and an EDV.

### The Power of the EDV

It was evident that the EDV plays a multifaceted role in the maintenance of participants' EDs. As aforementioned, the difficulty separating the self from the EDV and the perceived loss tied to recovery were key elements contributing to the maintenance of their EDs.

The perceived power the EDV held within the relationships was another maintaining factor. Participants described being "unable to say no" (Anne) to the EDV's demands with a narrative of the EDV "giving orders" (Jenny). Narratives suggested that the EDV uses their initial trusting relationship to build power and then adapts to manipulate them. They described the EDV's actions as it "sells you lies" (Anne) and "uses this [trauma] to manipulate me even more" (Karen). This was reflected in Karen's story who described the EDV adapting to maintain its own survival over time, stating that "it camouflages itself" and "the longer the ED voice has resided in my brain, the sneakier it has become". Karen felt that her thoughts and feelings were "being twisted and laced with poison" by the EDV, causing her to "question every thought" in recovery, therefore demonstrating how the perceived power of their EDV can contribute to the maintenance of an ED.

### Trapped in a Cycle by the EDV

The language used by participants denoted an inescapable battle within themselves: "like waking up each and every day to fight a war inside your own mind" (Anne). This combative imagery conveys the toll of managing their EDV.

Participants also utilised imagery of entrapment, where they feel like "a prisoner" (Jenny), "paralysed by the fear of never escaping its grasps" (Karen). The language used portrayed a sense that, despite their best efforts towards recovery, they remained powerless to the EDV's commands "despite having fallen down that hole too many times" (Anne). Within Max's poem, a repeated line states "live like I'm dying I'm dying to live" symbolising a cycle of desperation and feelings of entrapment or helplessness when experiencing an EDV. Within Karen's story, she doubts she can ever overthrow her EDV and expresses this "fear of never being free" from an EDV that simultaneously pushes her to "fight back and challenge myself…but it can also grind me to a complete halt", thus demonstrating that attempting to regain control of their EDV may feel impossible and inhibit recovery.

### Barriers to Accessing Support for Multiplicity and an EDV

Participants who experience multiplicity expressed a lack of representation in the current understanding of the EDV, which could act as a barrier to accessing support as they had "difficulty relating to the usual representation for ED voices" (Claire).

One key barrier in Claire's story was the lack of clinical understanding as they were previously misdiagnosed with schizophrenia. They states that "there isn't enough clinical understanding for how multiplicity overlaps with other conditions" and "our therapist focuses on us as individuals…but there is more than us being a bunch of people stuck together". They expressed that "true understanding lies between understanding us as voices, as independent individuals and as all thoughts of a single mind". Therefore, without this level of understanding within ED services, that support feels inaccessible to those with multiplicity and subsequently maintains their ED.

This lack of understanding translates to wider society and the stigma that surrounds the experience of multiplicity. Stigma was another significant character within the participants' narratives, with the presence of an EDV as an alter exasperating that stigma further. Claire expresses that "Multiplicity stigma exists" that leads her to question how to "phrase my experiences in a world where you existing as a singlet is a universal experience?". She has a "huge trouble even describing living as plural, let alone…that I have a starry red fox monster in my head who eats too much…. People would find it absurd" (Claire).

Participants highlighted the importance of having an understanding support system, finding comfort when expressing that “my family understand me” (Triss) or “plurals get us…singlet friends tend to become the confused but still supportive friends” (Claire). Therefore, the lack of understanding around multiplicity alongside an EDV acts as a barrier to accessing support both clinically and socially, as Claire states “getting over multiplicity stigma is the step forward, like unwrapping a box before being able to take the lid off”. Consequently, increased understanding would provide a safer environment to remove the lid, and cope with what is discovered about oneself.

## Discussion

This research explored how multiplicity and voice personification are experienced by young women who report the presence of an ED voice, self, or part. Through an adapted EBCD methodology, 11 participants’ stories were collected and analysed to further understanding of these multisensory experiences. This study makes a novel contribution to clinical psychology as previous research has not examined these seemingly distinct multisensory experiences simultaneously. It demonstrated the interwoven nature of multisensory experiences with the EDV along a continuum from voice-hearing to a distinct member of a system within multiplicity. By furthering the understanding of complex psychological phenomena within the context of EDs, it can aid development of effective ED interventions.

A majority of the presented narratives match those of earlier studies. For instance, participants’ experience of being trapped and powerless to the EDV mirrors earlier accounts of the EDV (Tierney & Fox, 2010; Williams & Reid, 2012). Furthermore, experiencing a shifting relationship with their EDV from a positive entity to a controlling and abusive relationship has also been documented within the literature (Dolhanty & Greenberg, 2007; Tierney & Fox, 2010). However, many participants expressed that their EDV has never offered guidance and reassurance. Instead, the initial positive relationship was in hindsight the ulterior motives of the EDV to build trust with the individual, allowing it to become an overpowering and controlling entity. These results highlight that, due to the EDV disguising its controlling tactics during the early stages of the ED, the relationship is more complex than this field of research originally thought.

Previous research has established that the EDV plays a crucial role in the maintenance of ED behaviours (Pugh & Waller, 2017). In particular, the stronger the perceived power of the EDV the greater the severity of the ED (Pugh & Waller, 2016). A sense of feeling trapped compounded with an attachment to the EDV makes recovery challenging, as behavioural change incites internal hostility with the EDV (Pugh, 2016). This notion that powerlessness paired with an attachment to the EDV maintains ED behaviours is supported by the narratives heard in this research. Participants felt trapped yet scared to let go of their EDV.

Participants also compared losing their EDV to ending a romantic relationship. This perceived loss was exasperated by their identity being consumed by their EDV during their ED. Without the EDV, they no longer knew themselves which made recovery appear threatening and maintained their ED behaviours. This narrative is consistent to previous research that examines sense of self within ED populations (Higbed & Fox, 2010; Williams et al., 2016). However, the findings of this research offer a further perspective. The experience of having their identity intertwined with the EDV made it difficult to let go but also meant they were unable to distinguish their own thoughts from the EDV’s, which led to a lack of trust to act upon thoughts when in recovery. In summary, the overpowering nature of the EDV impacts an individual’s identity which contributes to their difficulty to trust their own thoughts, reliance on the relationship with the EDV, and subsequent inability to let their EDV go, each contributing to the maintenance of their ED. Therefore, addressing this dynamic within ED treatment may be an important mechanism to aid stable recovery.

A particularly novel finding within the results was evidence of a continuum of EDV experiences from voice-hearing to the embodiment of an EDV within a system of multiple selves.

The language used to describe participants' EDVs aligned with the voice personification categories created by Alderson-Day et al. (2021). For example, the use of pronouns, names, and further detail regarding the intentions and actions of their EDV indicate both minimal and complex voice personification within participants' accounts. Furthermore, the position of the EDV on this continuum was also transient across the participants' stories. Although previous research has suggested that the EDV may exist at varying points along the voice-hearing continuum (Baumeister et al., 2017; Pugh et al., 2018), including accounts of an anorexic or bulimic "sub-self" separate to the individual's own self (Pugh, 2020; Sands, 1991), this research is the first to examine multiplicity in connection with an EDV. Two participants shared their story of experiencing an EDV as a member within their system. A key distinction from other participants' stories was that the EDV's actions within the system were felt physically. When their alter's hunger response was triggered, they described feeling tackled by the alter to engage in ED behaviours. Furthermore, the complex relationship with the EDV in the context of multiplicity is not represented by current literature. This experience consists of the EDV embodying a distinct self which is valued, loved, and considered a family member by the system which cannot be simply let go.

In summary, the results of this research offer a novel perspective on how the EDV can be experienced along the voice-hearing continuum. Therefore, future research should endeavour to include the unrepresented population of those with multiplicity within research samples and implement inclusive and collaborative methodologies such as EBCD to ensure mechanisms to address the EDV within ED treatment can be tailored effectively for the spectrum of EDV experiences.

## Clinical Implications

This research aimed to further understanding of the EDV and its complex relationship with the individual so that clinicians can effectively address the EDV within ED treatment. The salient message from Claire's narrative was that "recovery" is not homogenous along the continuum of EDV experiences. Reflected within their story and previous literature, their attachment may be deeper due to the EDV being a collectively supported member of their internal family. Therefore, the process and outcome of recovery in the context of multiplicity is different to experiences of a personified EDV. Throughout Claire's narrative, the tone suggested a bond between her system based on love and care for each other. Therefore, although loss within recovery can be experienced by anyone who lives with an EDV, recovery may be perceived as highly threatening to those experiencing multiplicity as it may involve the loss of a family member.

There is a lack of clinical understanding surrounding multiplicity that prevents this population from accessing ED treatment. At present, treatment pathways do not reflect the continuum of EDV experience nor its varied definitions of recovery. This population may benefit from increased collaboration between system members to elicit a group-based intervention to work together within their ED treatment. One possibility is the inclusion of Voice Dialogue within treatment (Stone & Stone, 1989), as this therapeutic method implements chair work to focus on communication and awareness between selves through the procedure of switching between chairs within dialogue to facilitate change (Pugh et al., 2021; Stone & Stone, 2007). By highlighting the spectrum of EDV experiences, this research aims to demonstrate the importance of adapting ED treatment pathways to meet the needs and treatment outcomes of this unheard population.

The lack of representation for multiplicity within current EDV literature and ED treatment highlights another barrier to this population accessing support: stigma. The results established that this population felt they were not understood or given a voice, in societal or clinical settings. Living as a single self is considered a universal experience, which makes sharing your story as a multiple feel exposing and threatening. During this process, participants shared feeling invalidated and misdiagnosed by professionals and manipulated by others in their life when they'd shared their multiplicity. Therefore, seeking clinical support to address their ED alongside their multiplicity can feel inaccessible. As a result, participants are attempting to manage their symptoms and implement coping strategies through collaboration between their system members without professional support. Based on the stories heard, an initial stage to make services more accessible could be continuous professional development sessions for staff within ED services to increase their understanding of multiplicity and information including appropriate language use. Furthermore, it may be beneficial to implement an EBCD service development project within an ED service that included the voices of this population. This project could be advertised on social media to recruit this hard-to-reach population and allow them to collaboratively create treatment pathways which meet their needs. As Claire stated, "getting over multiplicity stigma is the step forward, like unwrapping a box before being able to take the lid off". As clinicians, we should be striving to implement strategies that foster a safe environment that allows this population to share their experiences and access necessary support.

## Strengths, Limitations and Future Research

Participants were not required to disclose their ED diagnosis during the research. The inclusion criteria simply stated, "an experience of an eating disorder". This allowed for the inclusion of people known and not known to services, who may not have accessed clinical support or received a diagnosis. Thus, although the results suggest a continuum of EDV experiences, it cannot determine whether this can be attributed to specific ED diagnoses. Future research may benefit from developing an assessment or screening tool for ED services that explores the presence of this EDV continuum to acquire data from a larger sample of participants, including males, to establish how different factors, such as ED diagnoses and gender, contribute to the continuum of EDV experiences.

Previous research has pursued behavioural-based ED treatment to address the EDV. For example, encouraging the person to challenge the voice content and their beliefs about the voice's power alongside developing behavioural responses to achieve control over their ED (Pugh & Waller, 2017). However, this research has highlighted the complexity of the relationship individuals have with their EDV and how it intertwines with their identity. Therefore interventions, such as

Compassion Focused Therapy (Goss & Allan, 2014), Maudsley Model of Anorexia Nervosa Treatment for Adults (Schmidt et al., 2014), and Narrative Therapy (White & Epston, 1990) that can address the EDV relationship and its impact on identity directly may be more effective than the symptom focused approach within behavioural-based practice. It may be beneficial to implement a further EBCD research study, involving participants' stories, to design an effective relational-based approach collaboratively with a multi-disciplinary team. Future research could then strive to build an evidence-base for the co-designed intervention that addresses the relationship with the EDV through randomised control trials that allow for the rigorous testing to establish the effectiveness of an intervention.

## Conclusion

Currently, 5.5-17.9% of women in western cultures will experience an ED by young adulthood, with ED rapidly becoming a global concern (Silén & Keski-Rahkonen, 2022). This research aimed to explore multiplicity and voice personification alongside the presence of an ED voice, self, or part. The results demonstrated the existence of a spectrum of EDV experiences that included voice personification and multiplicity, therefore supporting the hypothesis of previous research that the EDV does not have a fixed position on the voice-hearing continuum (Baumeister et al., 2017; Pugh et al., 2018). Furthermore, the results provided insight into the mechanisms that underlie the EDV as a maintenance factor in EDs, such as their sense of self being encompassed by the EDV and the sense of loss attributed to recovery, particularly within the multiplicity population. This research contributes to the clinical psychology field by highlighting the need for effective interventions, collaboratively developed, that address the relationship with the EDV directly within ED treatments. It is important to state that participants who experience Multiplicity felt unheard and unrepresented by the current understanding of the EDV within the literature and clinical settings. Therefore, future research should define the EDV as a voice, presence, or self that may be distinct from, or connected to, the individual's own self that comments on individual's body shape, weight and eating habits.

Further collaboration between clinicians, researchers, and experts by experience within the multiplicity community is necessary to overcome stigma, create treatment pathways within services that are accessible to all, and to continue to be led by this unheard population.

## References

Alderson-Day, B., Woods, A., Moseley, P., Common, S., Deamer, F., Dodgson, G., & Fernyhough, C. (2021). Voice-hearing and personification: characterizing social qualities of auditory verbal hallucinations in early psychosis. *Schizophrenia Bulletin*, *47*(1), 228-236.

American Psychiatric Association, A. P. A. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (Vol. 5). American psychiatric association Washington, DC.

Atlas.ti. (n.d.) *Narrative analysis in research.* Retrieved January 16 2024 from https://atlasti.com/guides/qualitative-research-guide-part-2/narrative-research

Baumeister, D., Sedgwick, O., Howes, O., & Peters, E. (2017). Auditory verbal hallucinations and continuum models of psychosis: A systematic review of the healthy voice-hearer literature. *Clinical psychology review*, *51*, 125-141.

Beavan, V. (2011). Towards a definition of "hearing voices": A phenomenological approach. *Psychosis*, *3*(1), 63-73.

Bektas, S., Keeler, J. L., Anderson, L. M., Mutwalli, H., Himmerich, H., & Treasure, J. (2022). Disgust and self-disgust in eating disorders: a systematic review and meta-analysis. *Nutrients*, *14*(9), 1728.

Burnett-Stuart, S. (2021). *Interviewing'Ana': Thematic analysis of voice dialogues with the internal anorexic voice* UCL (University College London)].

Chadwick, P. D., Birchwood, M. J., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia*. John Wiley & Sons.

Collier, M. (2001). Approaches to analysis in visual anthropology. *Handbook of visual analysis*, 35-60.

Collins, L., Brezina, V., Demjén, Z., Semino, E., & Woods, A. (2023). Corpus linguistics and clinical psychology: Investigating personification in first-person accounts of voice-hearing. *International Journal of Corpus Linguistics*, *28*(1), 28-59.

Colmsee, I.-S. O., Hank, P., & Bošnjak, M. (2021). Low self-esteem as a risk factor for eating disorders. *Zeitschrift für Psychologie*.

Coons, P. M. (1998). The dissociative disorders: Rarely considered and underdiagnosed. *Psychiatric Clinics of North America*, *21*(3), 637-648.

Corstens, D., & Longden, E. (2013). The origins of voices: links between life history and voice hearing in a survey of 100 cases. *Psychosis*, *5*(3), 270-285.

Crossley, M. (2007). Analysing qualitative data in psychology.

Day, S., Hay, P., Tannous, W. K., Fatt, S. J., & Mitchison, D. (2023). A Systematic Review of the Effect of PTSD and Trauma on Treatment Outcomes for Eating Disorders. *Trauma, Violence, & Abuse*, 15248380231167399.

Diemer, E. W., White Hughto, J. M., Gordon, A. R., Guss, C., Austin, S. B., & Reisner, S. L. (2018). Beyond the binary: differences in eating disorder prevalence by gender identity in a transgender sample. *Transgender Health*, *3*(1), 17-23.

Dolhanty, J., & Greenberg, L. S. (2007). Emotion-focused therapy in the treatment of eating disorders. *European Psychotherapy*, *7*(1), 97-116.

Esin, C., Fathi, M., & Squire, C. (2014). Narrative analysis: The constructionist approach. *The SAGE handbook of qualitative data analysis*, 203-216.

Eve, Z., & Parry, S. (2021). Exploring the experiences of young people with multiplicity. *Youth and Policy*.

Fylan, B., Tomlinson, J., Raynor, D. K., & Silcock, J. (2021). Using experience-based co-design with patients, carers and healthcare professionals to develop theory-based interventions for safer medicines use. *Research in Social and Administrative Pharmacy*, *17*(12), 2127-2135.

Geelan, D. R. (1996). Learning to communicate: developing as a science teacher. *Australian Science Teachers Journal*, *42*(1), 30-34.

Gibbs, G. (2007). *Analyzing Qualitative Data* https://doi.org/10.4135/9781849208574

Girling, M., Le Couteur, A., & Finch, T. (2022). Experience-based co-design (EBCD) with young people who offend: Innovating methodology to reach marginalised groups. *PloS one*, *17*(7), e0270782.

Gordon, A. R., Moore, L., & Guss, C. (2021). Eating disorders among transgender and gender non-binary people. *Eating disorders in boys and men*, 265-281.

Goss, K., & Allan, S. (2014). The development and application of compassion-focused therapy for eating disorders (CFT-E). *British Journal of Clinical Psychology*, *53*(1), 62-77. https://doi.org/doi:10.1111/bjc.12039

Gustavsson, S. M., & Andersson, T. (2019). Patient involvement 2.0: experience-based co-design supported by action research. *Action research*, *17*(4), 469-491.

Haines, K. J., Holdsworth, C., Cranwell, K., Skinner, E. H., Holton, S., MacLeod-Smith, B., Bates, S., Iwashyna, T. J., French, C., & Booth, S. (2019). Development of a peer support model using experience-based co-design to improve critical care recovery. *Critical Care Explorations*, *1*(3).

Higbed, L., & Fox, J. R. (2010). Illness perceptions in anorexia nervosa: A qualitative investigation. *British Journal of Clinical Psychology*, *49*(3), 307-325.

James, W. (2023). Structural Narrative Analysis. In *Varieties of Qualitative Research Methods: Selected Contextual Perspectives* (pp. 451-455). Springer.

Keel, P. K., & Forney, K. J. (2013). Psychosocial risk factors for eating disorders. *International Journal of Eating Disorders*, *46*(5), 433-439.

Kent, A., & Waller, G. (2000). Childhood emotional abuse and eating psychopathology. *Clinical psychology review*, *20*(7), 887-903.

Kincheloe, J. L. (2005). Critical constructivism primer (Vol. 2). Peter Lang.

Lyons, L. (2017). *The Rise of Eating Disorders in Developing Countries*. Eating Disorder Hope. https://www.eatingdisorderhope.com/blog/eating-disorders-developing-countries

Marffy, M. J., Fox, J., & Williams, M. (2023). An exploration of the relationship between loneliness, the severity of eating disorder-related symptoms and the experience of the ‘anorexic voice’. *Psychology and Psychotherapy: Theory, Research and Practice*.

McRae, L., Hundley, G., Bell, H., & Fox, J. (2017). Stories of Survivors With Dissociative Identity Disorder: A Qualitative Investigation of Symptoms, Traumatic Experiences, and Relationships.

National Institute for Health and Care Excellence (2017). Eating disorders: recognition and treatment [NICE Guideline NG69]. https://www.nice.org.uk/guidance/ng69/

NHS England. (2022, March) *NHS treating record number of young people for eating disorders.* *https://www.england.nhs.uk/2022/03/nhs-treating-record-number-of-young-people-for-eating-disorders/*

Noordenbos, G., Aliakbari, N., & Campbell, R. (2014). The relationship among critical inner voices, low self-esteem, and self-criticism in eating disorders. *Eating disorders*, *22*(4), 337-351.

Noordenbos, G., & Van Geest, Z. (2017). Self-criticism and critical voices in eating disorder patients and healthy controls. *JSM Nutritional Disorders*, *1*(1), 1003.

Parry, S., Lloyd, M., & Simpson, J. (2018). “It's not like you have PSTD with a touch of dissociation”: Understanding dissociative identity disorder through first person accounts. *European Journal of Trauma & Dissociation*, *2*(1), 31-38.

Parry, S., Loren, E., & Varese, F. (2021). Young people's narratives of hearing voices: Systemic influences and conceptual challenges. *Clinical Psychology & Psychotherapy*, *28*(3), 715-726.

Phillipou, A., Meyer, D., Neill, E., Tan, E. J., Toh, W. L., Van Rheenen, T. E., & Rossell, S. L. (2020). Eating and exercise behaviors in eating disorders and the general population during the COVID-19 pandemic in Australia: Initial results from the COLLATE project. *International Journal of Eating Disorders*, *53*(7), 1158-1165.

Point of Care Foundation. (n.d). *EBCD: Experience-based Co-design toolkit.* Retrieved January 5 2023 from https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/

Pugh, M. (2016). The internal ‘anorexic voice’: a feature or fallacy of eating disorders? *Advances in Eating Disorders*, *4*(1), 75-83.

Pugh, M. (2020). Understanding ‘Ed’: a theoretical and empirical review of the internal eating disorder ‘voice.’. *BPS Psychother Sect Rev*, *65*, 12-23.

Pugh, M., Bell, T., & Dixon, A. (2021). Delivering tele-chairwork: A qualitative survey of expert therapists. *Psychotherapy Research*, *31*(7), 843-858.

Pugh, M., & Waller, G. (2016). The anorexic voice and severity of eating pathology in anorexia nervosa. *International Journal of Eating Disorders*, *49*(6), 622-625.

Pugh, M., & Waller, G. (2017). Understanding the ‘anorexic voice’in anorexia nervosa. *Clinical Psychology & Psychotherapy*, *24*(3), 670-676.

Pugh, M., Waller, G., & Esposito, M. (2018). Childhood trauma, dissociation, and the internal eating disorder ‘voice’. *Child Abuse & Neglect*, *86*, 197-205.

Raynor, D. K., Ismail, H., Blenkinsopp, A., Fylan, B., Armitage, G., & Silcock, J. (2020). Experience-based co-design—adapting the method for a researcher-initiated study in a multi-site setting. *Health Expectations*, *23*(3), 562-570.

Reinders, A. A., & Veltman, D. J. (2021). Dissociative identity disorder: out of the shadows at last?. The British Journal of Psychiatry, 219(2), 413-414.

Ribáry, G., Lajtai, L., Demetrovics, Z., & Maraz, A. (2017). Multiplicity: An explorative interview study on personal experiences of people with multiple selves. *Frontiers in Psychology*, *8*, 938.

Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of Eating Disorders*, *48*(2), 187-198.

Rothschild, D. (2009). On becoming one-self: Reflections on the concept of integration as seen through a case of dissociative identity disorder. *Psychoanalytic Dialogues*, *19*(2), 175-187.

Sands, S. (1991). Bulimia, dissociation, and empathy: A self-psychological view. Earlier versions of the chapter were presented at the 12th Annual Conference on the Psychology of the Self, San Francisco, CA, Oct 12-15, 1989, and at the Division 39 (Psychoanalysis) American Psychological Association meeting, New York, NY, Apr 5-8, 1990., Sar, V. (2011). Epidemiology of dissociative disorders: An overview. *Epidemiology research international*, *2011*.

Scharmer, C., Martinez, K., Gorrell, S., Reilly, E. E., Donahue, J. M., & Anderson, D. A. (2020). Eating disorder pathology and compulsive exercise during the COVID-19 public health emergency: Examining risk associated with COVID-19 anxiety and intolerance of uncertainty. *International Journal of Eating Disorders*, *53*(12), 2049-2054.

Schmidt, U., Wade, T. D., & Treasure, J. (2014). The Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA): development, key features, and preliminary evidence. *Journal of cognitive psychotherapy*, 28(1).

Silén, Y., & Keski-Rahkonen, A. (2022). Worldwide prevalence of DSM-5 eating disorders among young people. *Current Opinion in Psychiatry*, *35*(6), 362-371.

Simeon, D., Simeon, D., & Abugel, J. (2023). *Feeling unreal: Depersonalization and the loss of the self*. Oxford University Press.

Simone, M., Hazzard, V. M., Askew, A. J., Tebbe, E. A., Lipson, S. K., & Pisetsky, E. M. (2022). Variability in eating disorder risk and diagnosis in transgender and gender diverse college students. *Annals of epidemiology*, *70*, 53-60.

Smith, B. (2016). Narrative analysis. *Analysing qualitative data in psychology*, *2*, 202-221.

Solmi, M., Radua, J., Stubbs, B., Ricca, V., Moretti, D., Busatta, D., Carvalho, A. F., Dragioti, E., Favaro, A., & Monteleone, A. M. (2020). Risk factors for eating disorders: an umbrella review of published meta-analyses. *Brazilian Journal of Psychiatry*, *43*, 314-323.

Spanos, N. P. (1994). Multiple identity enactments and multiple personality disorder: a sociocognitive perspective. *Psychological bulletin*, *116*(1), 143.

Spikol, A., & Murphy, J. (2019). ‘Something wasn’t quite right’: a novel phenomenological analysis of internet discussion posts detailing initial awareness of psychosis. *Clinical Schizophrenia & Related Psychoses*.

Stone, H., & Stone, S. (1989). *Embracing our selves: The voice dialogue manual*. New World Library.

Stone, H., & Stone, S. (2007). The basic elements of Voice Dialogue, relationship and the Psychology of Selves: Their origins and development. *SL Stone & H. Stone The Voice Dialogue Anthology. Explorations of the Psychology of Selves and the Aware Ego Process*, 7-49.

Tierney, S., & Fox, J. R. (2010). Living with the anorexic voice: A thematic analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(3), 243-254.

Wang, P. S., Demler, O., & Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. *American journal of public health*, *92*(1), 92-98.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. WW Norton & Company.

Wilkinson, S., & Bell, V. (2016). The representation of agents in auditory verbal hallucinations. *Mind & language*, *31*(1), 104-126.

Williams, K., King, J., & Fox, J. R. (2016). Sense of self and anorexia nervosa: A grounded theory. *Psychology and Psychotherapy: Theory, Research and Practice*, *89*(2), 211-228.

Williams, S., & Reid, M. (2012). ‘It's like there are two people in my head’: A phenomenological exploration of anorexia nervosa and its relationship to the self. *Psychology & health*, *27*(7), 798-815.

Young Voices Study. (2021). Understanding Multiplicity. https://www.mmu.ac.uk/sites/default/files/2021-02/Understanding%20multiplicity.pdf

**Figure 2-1.**

*Proposed continuum of voice hearing within adolescents with multisensory and multi-self experiences.*

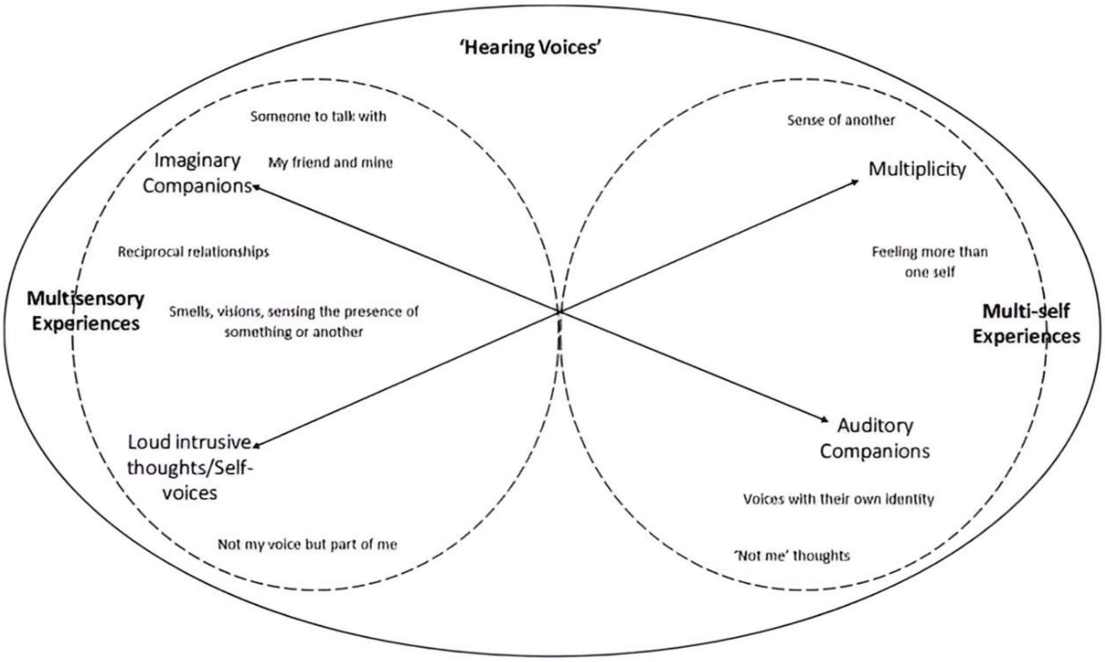
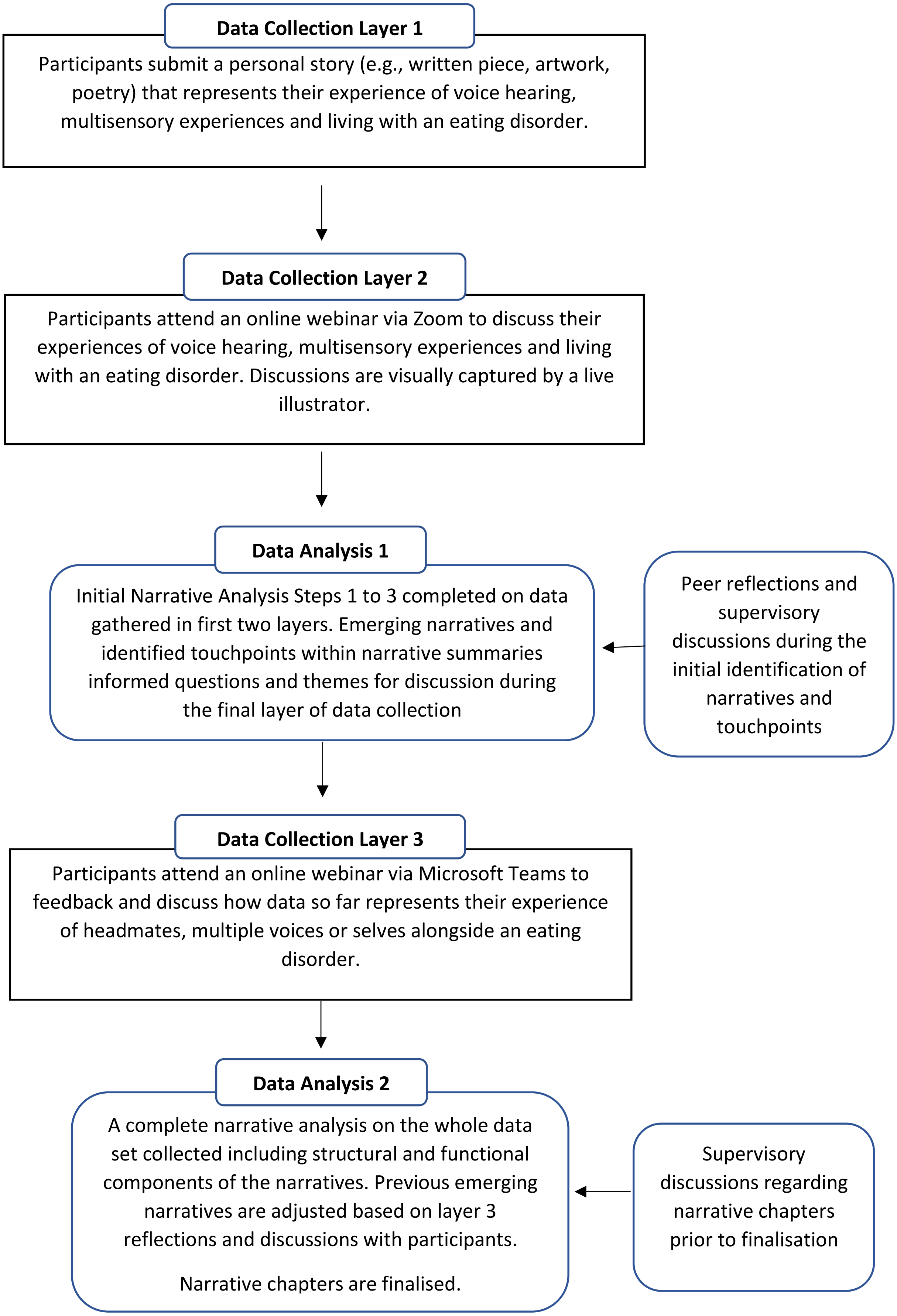


**Figure 2-2.**

*EBCD Informed Layers of Data Collection*



Participants submit a personal story (e.g., written piece, artwork, poetry) that represents their experience of voice hearing, multisensory experiences and living with an eating disorder.

Participants attend an online webinar via Zoom to discuss their experiences of voice hearing, multisensory experiences and living with an eating disorder. Discussions are visually captured by a live illustrator.

Initial Narrative Analysis Steps 1 to 3 completed on data gathered in first two layers. Emerging narratives and identified touchpoints within narrative summaries informed questions and themes for discussion during the final layer of data collection

Peer reflections and supervisory discussions during the initial identification of narratives and touchpoints

Participants attend an online webinar via Microsoft Teams to feedback and discuss how data so far represents their experience of headmates, multiple voices or selves alongside an eating disorder.

A complete narrative analysis on the whole data set collected including structural and functional components of the narratives. Previous emerging narratives are adjusted based on layer 3 reflections and discussions with participants.

Narrative chapters are finalised.

Supervisory discussions regarding narrative chapters prior to finalisation

**Table 2-1.**

*Demographic Characteristics of Participants*

| Demographic Variables | Layer of Data Collection | | |
|---|---|---|---|
| | Layer 1 (*n* = 10) | Layer 2 (*n* = 3) | Layer 3 (*n* = 2) |
| Gender *N* (%) | | | |
| Female | 10 (100) | 2 (100) | 3 (100) |
| Age, years, mean | 21.5 | 21 | 21 |
| Ethnicity *N* (%) | | | |
| White British | 6 (60) | 2 (66.67) | 1 (50) |
| Caucasian-Asian | 1 (10) | 1 (33.33) | 1 (50) |
| Brazilian | 1 (10) | 0 (0) | 0 (0) |
| Filipino | 1 (10) | 0 (0) | 0 (0) |
| Australian | 1 (10) | 0 (0) | 0 (0) |
| Location *N* (%) | | | |
| United Kingdom | 6 (60) | 2 (66.67) | 1 (50) |
| Canada | 2 (20) | 1 (33.33) | 1 (50) |
| Philippines | 1 (10) | 0 (0) | 0 (0) |
| Tasmania | 1 (10) | 0 (0) | 0 (0) |
| Duration of Eating Disorder, years, mean | 6.4 | 6.6 | - |
| Duration of voice hearing experiences, years, mean | 5 | 8 | - |
| Duration of multisensory experiences, years, mean | 1.9 | 2 | - |

*Note. A proportion of participants were retained between layers of data collection*

**Figure 2-3.**

*Consort Flowchart of Participants*

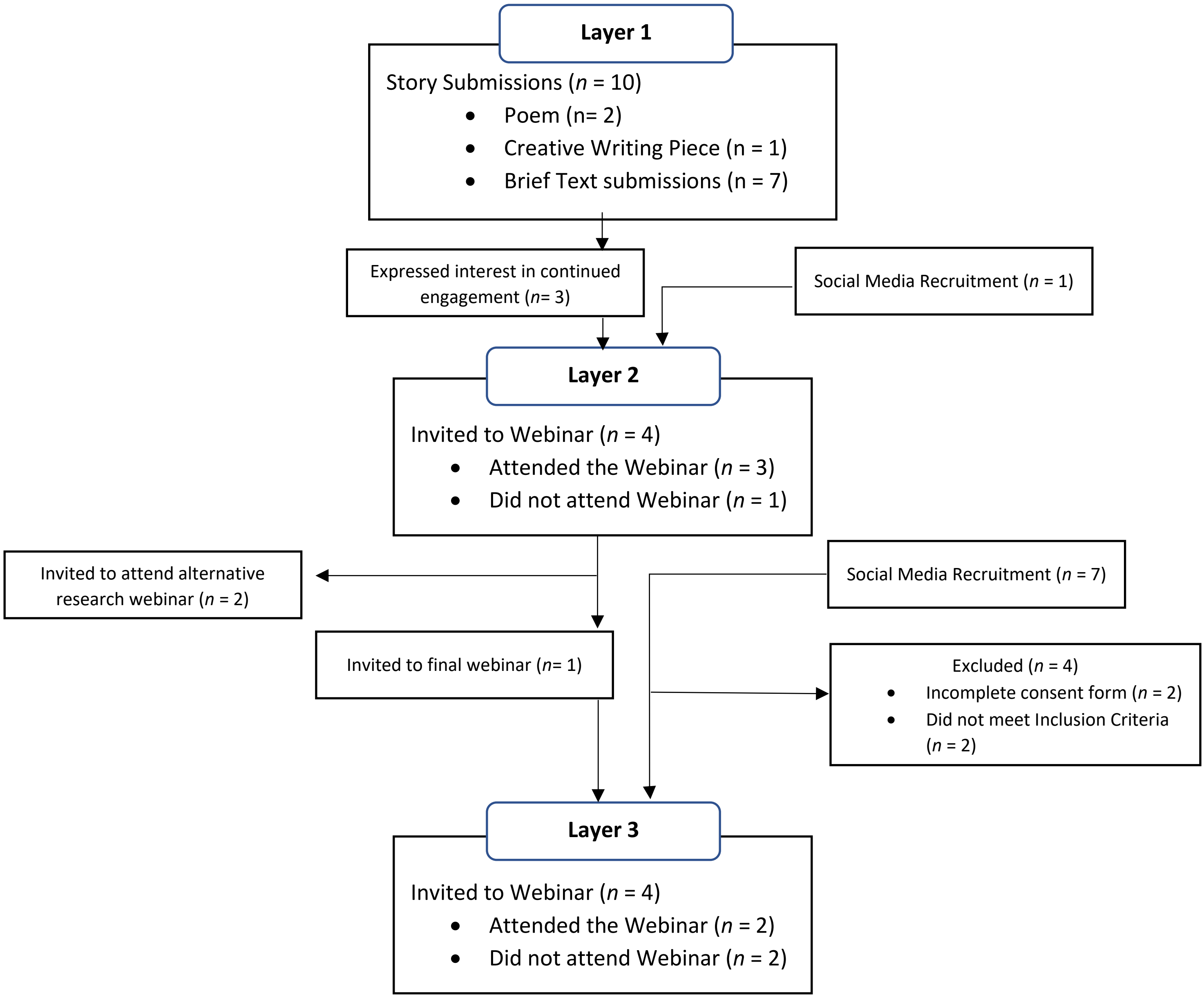
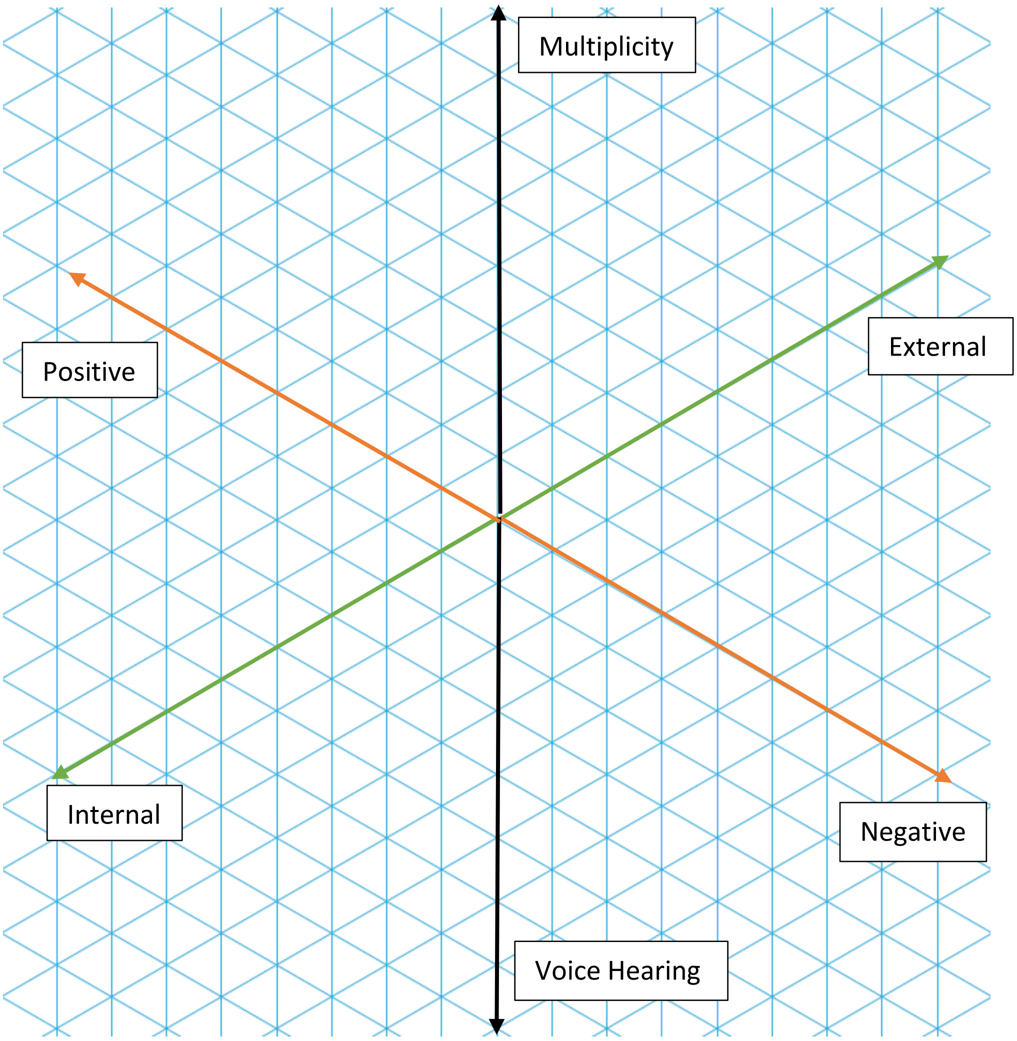


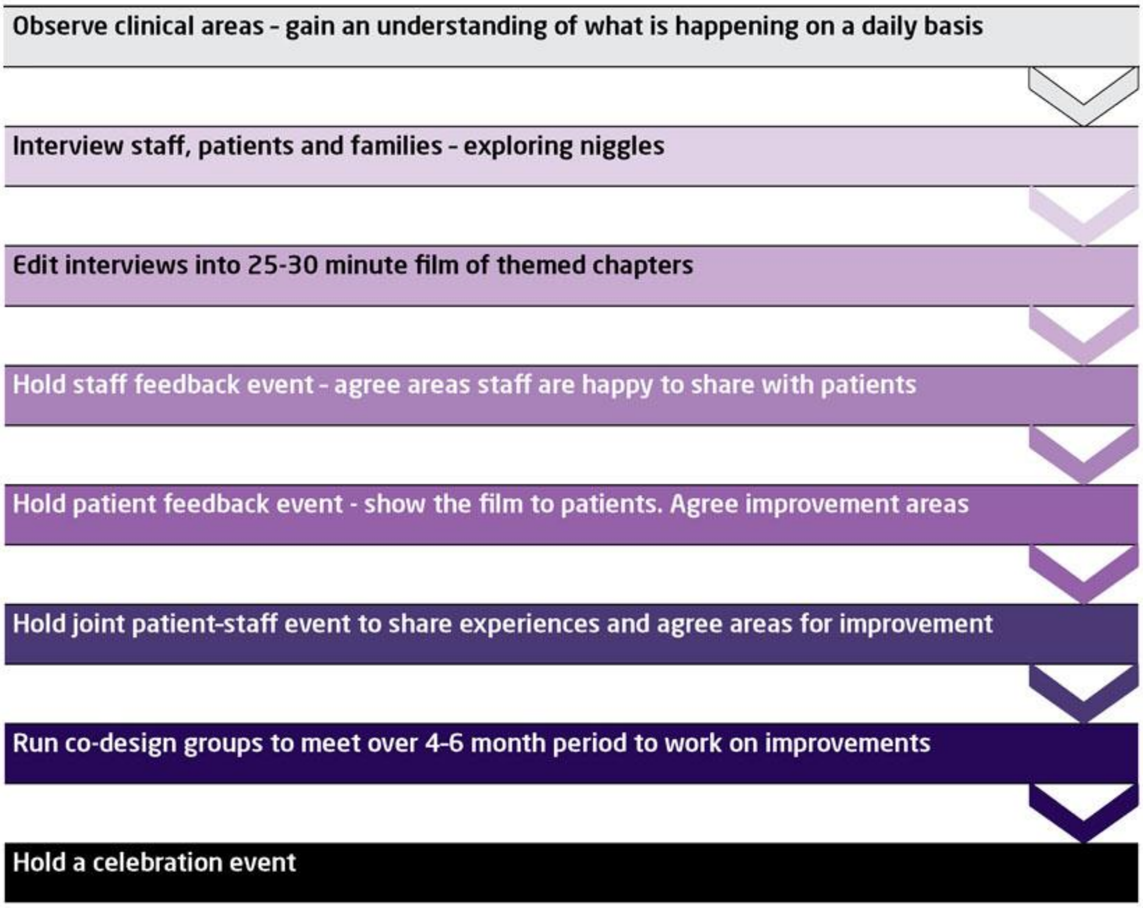
**Figure 2-4.**

*A schematic diagram to visually represent the interconnected continuums of the EDV*



## Appendix 2-A

**Figure A1: Point of Care Foundation. (n.d). EBCD: Experience-based Co-design toolkit - Stages of EBCD Methodology**



Observe clinical areas - gain an understanding of what is happening on a daily basis

Interview staff, patients and families - exploring niggles

Edit interviews into 25-30 minute film of themed chapters

Hold staff feedback event - agree areas staff are happy to share with patients

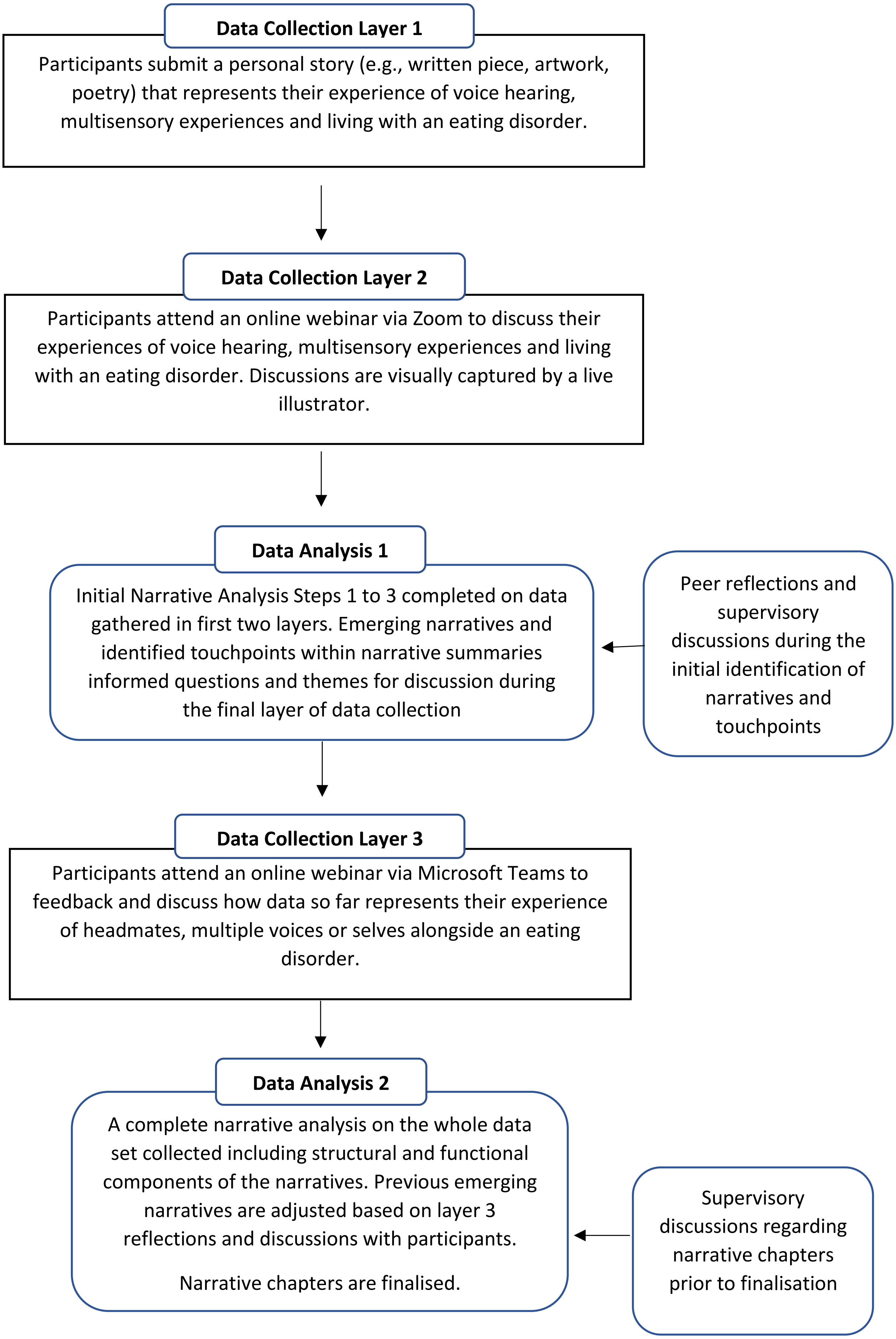
Hold patient feedback event - show the film to patients. Agree improvement areas

Hold joint patient-staff event to share experiences and agree areas for improvement

Run co-design groups to meet over 4-6 month period to work on improvements

Hold a celebration event

**Figure A2: EBCD Informed Procedure**



**Data Collection Layer 1**

Participants submit a personal story (e.g., written piece, artwork, poetry) that represents their experience of voice hearing, multisensory experiences and living with an eating disorder.

**Data Collection Layer 2**

Participants attend an online webinar via Zoom to discuss their experiences of voice hearing, multisensory experiences and living with an eating disorder. Discussions are visually captured by a live illustrator.

**Data Analysis 1**

Initial Narrative Analysis Steps 1 to 3 completed on data gathered in first two layers. Emerging narratives and identified touchpoints within narrative summaries informed questions and themes for discussion during the final layer of data collection

Peer reflections and supervisory discussions during the initial identification of narratives and touchpoints

**Data Collection Layer 3**

Participants attend an online webinar via Microsoft Teams to feedback and discuss how data so far represents their experience of headmates, multiple voices or selves alongside an eating disorder.

**Data Analysis 2**

A complete narrative analysis on the whole data set collected including structural and functional components of the narratives. Previous emerging narratives are adjusted based on layer 3 reflections and discussions with participants.

Narrative chapters are finalised.

Supervisory discussions regarding narrative chapters prior to finalisation

## Appendix 2-B

## Illustration of Online Group Discussion – Data Collection Layer Two

*Note.* *Illustrated by Emma Paxton*

## Appendix 2-C

## Narrative Analysis Framework

| | Step 1 | Step 2 | Step 3 | Step 4 | Step 5 | Step 6 |
|---|---|---|---|---|---|---|
| **Audio Data** | **Transcribe** | **Follow Text Process** | | | | |
| **Visual data**<br>**(Collier, 2001)** | **Familiarisation** | **Categorising based on research question (deductive)** | **Produce detailed summaries of categorised visual data** | **Develop overarching layers of 'meaning and significance' based on whole data set** | **Weaving all of this together in a coherent story** | **Writing up as a research report** |
| **Text data (Crossley, 2007)** | **Reading and familiarising** | **Identifying important concepts to look for (specifically tone, imagery, and themes)** | **Identifying narrative tone** | **Identifying narrative themes and images** | | |
| **Additional steps** | | **Define deductive categories based on research question** | | **Mesh inductive and deductive themes from both data types.**<br>**Critically consider structure, function and the role of self-stigma and cultural stigma** | | |
| **Analytic actions:** | **Transcribe audio data**<br>**Familiarisation and initial note** | **Develop deductive categories**<br>**Inductively identify concepts from data** | **Create summary stories for each participant's narratives** | **Consider Structural Narrative Analysis – tonality, pace and language used** | **Grouped related narrative themes, imagery, and touchpoints together** | **Finalising Chapter Titles and Core Narrative Themes** |

| | | | | | | |
|---|---|---|---|---|---|---|
| | **taking of observations** | **Keep notes on tonality, presentation and style** | | **Consider Functional Narrative Analysis – content and structure**<br>**Consider – Socio-Cultural themes– society's perception of the narrative** | **Synthesise groupings into coherent Core Narratives that represent participant's stories**<br>**Identified overarching layers between core narratives to form Chapters** | **Selecting appropriate quotes and evidence within core narratives** |

## Appendix 2-D

## Narrative Analysis Process

### Table D1: Illustrative quotes of Chapters and the Core Narratives

| Chapter | Core Narratives | Illustrative Quotes |
|---|---|---|
| A Continuum of the Eating Disorder Voice Experiences | The EDV on the Continuum of Multisensory and Multi-self experiences | “The voice and these thoughts are not mine” (Karen)<br>“I’ve never been able to imagine it’s a person or give it a name” (Karen)<br>“Adam” (Anne)<br>“The Scientists” (Anne)<br>“It’s bitchy little self” (Karen)<br>“Trust me she’s tried” (Max)<br>“Wild animals, hungry dogs” (Claire)<br>“like it feels like an actual person” (Karen)<br>“Has a mind of it’s own” (Anne)<br>“They’re sneaky about it” (Karen)<br>“Sometimes I hear the voices of my parents” (Karen)<br>“Our hungry alter is the personification of that voice” (Claire)<br>“I’m the condensation of all the eating disorder voices” (Claire)<br>“Most of us honestly don’t have involvement with any symptoms of ED. It’s just the host and the hungry alter” (Claire)<br>“The fear of starvation I’ve experienced as a child it sort of got isolated out into a single person within the system” (Claire)<br>“A special kind of switching where it feels like it catches whomever fronting off guard and rushes them from behind tackling them and running them over straight towards front with no communication or collaboration” (Claire)<br>“An internal experience that is connected to me” (Triss)<br>“Ed recovery is much closer to supporting a family member with an addiction than a singlet recovering from their own ED” (Claire)<br>“dissociated from real life” (Karen)<br>“not fully present” (Anne) |

| | | |
|---|---|---|
| | The Eating Disorder Voice and Me | “This thing in my brain” (Karen)<br>“An internal experience connected to me” (Triss)<br>“Fighting something inside of me” (Claire)<br>“The anorexic voice in my head” (Brianna)<br>“A shadow that lives in my brain” (Madi)<br>“Living rent free in my mind” (Karen)<br>“The ED voice has resided in my brain” (Karen)<br>“A pet they tolerate” (Claire)<br>“a starry red fox monster who is out of this world” (Claire)<br>“A parasite in your brain that is both your worst enemy and very best friend” (Anne)<br>“Oh you’ve got to fight it it was like what like myself so then it sort of encouraged that like urge to destroy myself rather than the other thing that they were able to see was like a parasite on me. So yeah like I can see now how it is like you’re fighting against some of the sort of illness like a parasite erm but at the time I think I found it quite difficult to see it that way yeah” (Anne)<br>“Someone talking over my shoulder” (Madi)<br>“Loud screaming voice” (Karen)<br>“dictator” (Brianna)<br>“Entity that takes over” (Jenny) |
| | The Relationship with the Eating Disorder Voice | “I’ve never experienced it in a positive way, it has never been my friend” (Karen)<br>“It’s commanding and critical” (Anne)<br>“Have no control over it” (Triss)<br>“felt controlled by it and as if I have to obey its orders” (Jenny)<br>“An abusive partner will like try and isolate you from people that would keep you safe and be like your safety net it’s like an eating disorder does that as well” (Anne)<br>“isn’t it healthy no it’s not baby” (Max)<br>“A parasite in your brain that is both your worst enemy and very best friend” (Anne)<br>“it saved my life” (Karen)<br>“described differently throughout it’s different stages” (Anne)<br>“it’s an ever-changing thing” (Claire)<br>“loud demanding crys now silent adaptions” (Karen) |

| | | |
|---|---|---|
| | | "it can seem protective and helpful and even like a confident boost like again like kind of like the way that like an abusive partner will try and like love bomb at first and like say that you're like amazing and like get you hooked on them" (Anne)<br>"my system has taken extra care of me" (Claire)<br>"it's definitely not the same as it was when I first became unwell" (Karen)<br>"I the person fronting love XXX, I love him and any effort to support him (feeding him enough, weight watching, reassurance about financial security and access to food) is worth it. I think other alters find it annoying, stress inducing or like XXX may be a burden on us, one more symptom to manage in a complicated situation" (Claire) |
| Conflict between the self and the EDV | Conflict in Identity | "I feel I am the EDV" (Claire)<br>"It's will became mine" (Anne)<br>"without an ED, I don't know who I am"<br>"the voice comes from within themselves yet without much separation from the EDV" (Claire)<br>"It was really easy to recognise I think at the beginning… it's like two balls of wool that were tangled up together and my brain was say, red and the eating disorder was black so you could really distinguish between my thoughts and the eating disorder voice whereas the longer that I've had the eating disorder, the more entwined it's kind of become in my own thoughts and now it's like my brain and the eating disorder voice are like two different shades of red, so you can barely tell them apart" (Karen) |
| | Conflict in Recovery | "You don't even know if you're fighting against your own voice" (Karen)<br>"I'm protecting one part of my body" (Triss)<br>"It felt like a loss like a break up or something like that like even though he was so bad for me I was like I felt really lost without him anymore and I didn't know what to do and I had no purpose or direction" (Anne)<br>"It feels like a massive massive lost it feels like breaking up with someone but breaking up with yourself" (Karen)<br>"it feels like if I lose the eating disorder I'm going to lose a piece of my puzzle, a piece of my life and a piece of me and it's just gonna be like this gaping hole inside of me" (Karen)<br>"there will never be a fix without taking away our loved one" (Claire)<br>"hard to let go because it's one of us" (Claire) |

| | | |
|---|---|---|
| The Role of an EDV in the Maintenance of an Eating Disorder | The Power of the EDV | “Unable to say no to it” (Anne)<br>“giving orders” (Jenny)<br>“The ED sells you lies” (Anne)<br>“The EDV uses this to manipulate me even more” (Karen)<br>“it camouflages itself” (Karen)<br>“the longer the ED voice has resided in my brain the sneakier it has become” (Karen)<br>“It is much harder to share and much more isolating to experience your own thoughts and feelings being twisted and laced with poison than it is to hear a voice which sounds so different in tone that is obviously does not belong to you” (Karen)<br>“this leaves me questioning every thought entering my awareness” (Karen) |
| | Trapped in a cycle by the EDV | “like waking up each and every day to fight a war inside your own mind” (Anne)<br>“a prisoner just watching” (Jenny)<br>“paralysed by the fear of never escaping its grasps” (Karen)<br>“despite having fallen down that hole too many time” (Anne)<br>“I live like I’m dying I’m dying to live” (Max)<br>“The fear of never being free can at the best of times push me to fight back and challenge myself in terms of facing fear foods or putting myself in uncomfortable situations… but it can also grind me to a complete halt” (Karen) |
| | Barriers to Accessing Support for Multiplicity and an EDV | “difficulty relating to the usual representation for ED voices” (Claire)<br>“there isn’t enough clinical understanding for how multiplicity overlaps with other conditions” (Claire)<br>“out therapist focuses on us as individuals…but there is more than us being a bunch of people stuck together. We’re all voices and these voices borrow from conditions we suffer from and speak out thoughts intrusive or not” (Claire)<br>“true understanding lies between understanding us as voices as independent individuals and as all thoughts of a single mind” (Claire)<br>“Multiplicity stigma exists, but my personal circles have generally been kind to me about it. The hardest part is how do I even phrase my experiences in a world where you existing as a singlet is a universal experience? I have huge trouble even describing living as plural, let alone start on the fact that I have a starry red fox monster in my head who eats too much for me to physically handle but I also can’t get rid of him because he’s a family |

| | |
|---|---|
| | member. People would find it absurd and so I don’t even talk much about this to close friends of the system” (Claire)<br>“my family understands me” (Triss)<br>“Plurals get us, plural friends are rare but get us really easily. Singlet friends tend to become the confused but still supportive friends. We appreciate them all honestly” (Claire)<br>“getting over multiplicity stigma is the step forward, like unwrapping a box before being able to take that lid off” (Claire). |

**Table D2: Example of Coded Extract – Written Story from Layer One**

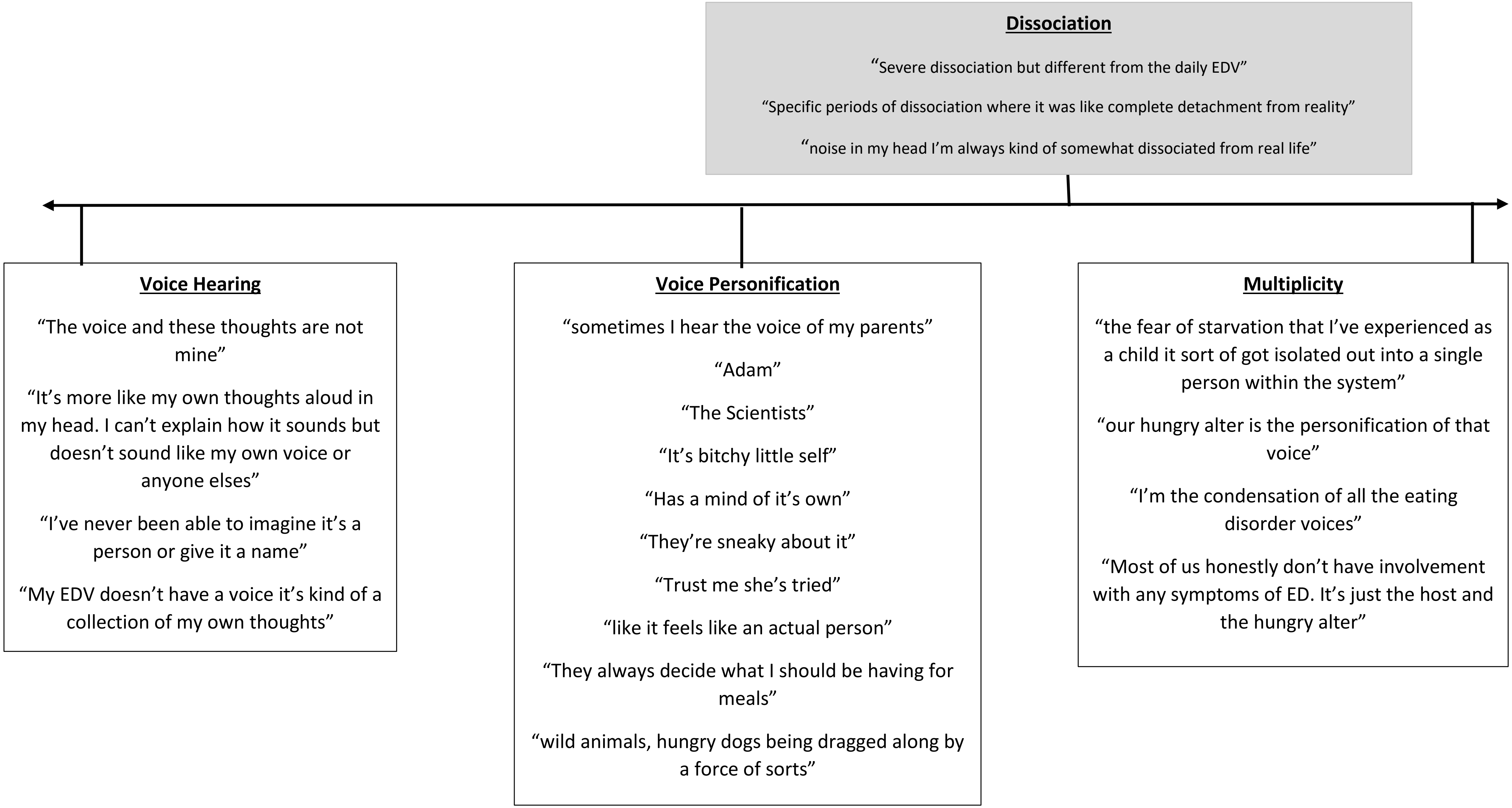
| Data | Narrative Codes |
|---|---|
| I have a voice living rent-free in my mind. It is almost impossible to describe and doesn't sound like anyone I have ever known. It camouflages itself amongst my own thoughts and feelings like two tangled balls of wool in two different shades of grey: leading me to believe that its painful, irrational and, quite frankly, deadly suggestions in fact belong to me. But this voice and these thoughts are not mine. It is not the voice of reason as it sometimes infers. It is the voice of an eating disorder known as Anorexia. | Language used – suggests internal experience of something living "in" her mind.<br>The use of the camouflage suggests the actions and intentions of the voice – adapting for survival.<br>Imagery of the two shades of grey shows attempts to distinguish herself from the EDV - Loss of identity and sense of self. |
| A voice that has controlled my life for the best part of 8 years. | Actions and intentions of the EDV – the persuasive nature of the EDV.<br>Tone of feeling helpless and powerless to the EDV. |
| The longer the ED voice has resided in my brain, the sneakier it has become and the less distinguished it is against my own. What was once a loud and demanding cry, blindingly obvious red strands of wool amongst the grey, has morphed into silent adaptations to my own thoughts and feelings. | Allows the listener insight into the progression of the EDV over the duration of her ED.<br>Repeating back to the previous imagery used.<br>Language used – "morphed" – changed over time. The intentions of the ED to "adapt". |
| Recognising what wholeheartedly feels like my own ideas to be the voice of my ED is like spotting a needle in a haystack. When in recovery, this leaves me questioning every thought entering my awareness. | The tone reflects how difficult/impossible recovery feels because of the EDV.<br>Function? – use of idiom "need in a haystack" and the imagery of spell check to aid understanding for the listener? |
| Scanning the same sentence over and over again like spell check on my computer, trying to ascertain whether there is any chance it could have been even slightly tampered with. | Actions of the EDV – tampering with thoughts |
| When I am overwhelmed, lacking in motivation or simply exhausted by life it leaves me in a trance like state. I am consumed by a never-ending conveyor belt of demands and paralysed by the fear of never escaping its grasps. | Imagery – relentless demands of the EDV like a conveyor belt.<br>"Its grasps" – Voice personification |
| When I was in a stronger place in my recovery in November of 2022, I took a trip to New York for a few days. | Structure is taking us through the journey – before was her current experience and this is reflections on a "stronger" part of her recovery journey. |
| Recovery had enabled me to finally live one of my younger self's dreams. Potentially the most destructive characteristic of the ED voice is its silence and invisibility to everyone but the sufferer themselves. | "finally" – tone of happiness of what she was able to achieve yet paired with what her ED took from her.<br>"destructive characteristic" – voice personification.<br>Tone – isolating experience of living with an EDV. |
| Each day I spent desperately trying to just be me was plagued by self-doubt. | "trying to just be me" – loss of identity and sense of self |

*Note. Key*: *Language and Images*, *Tone*, *Structural*, *Functional*, *Socio-Cultural*

## Appendix 2-E

## The Eating Disorder Voice Continuum

**Figure E1: The Continuum of the Eating Disorder Voice**



**Dissociation**

“Severe dissociation but different from the daily EDV”

“Specific periods of dissociation where it was like complete detachment from reality”

“noise in my head I’m always kind of somewhat dissociated from real life”

**Voice Hearing**

“The voice and these thoughts are not mine”

“It’s more like my own thoughts aloud in my head. I can’t explain how it sounds but doesn’t sound like my own voice or anyone elses”

“I’ve never been able to imagine it’s a person or give it a name”

“My EDV doesn’t have a voice it’s kind of a collection of my own thoughts”

**Voice Personification**

“sometimes I hear the voice of my parents”

“Adam”

“The Scientists”

“It’s bitchy little self”

“Has a mind of it’s own”

“They’re sneaky about it”

“Trust me she’s tried”

“like it feels like an actual person”

“They always decide what I should be having for meals”

“wild animals, hungry dogs being dragged along by a force of sorts”

**Multiplicity**

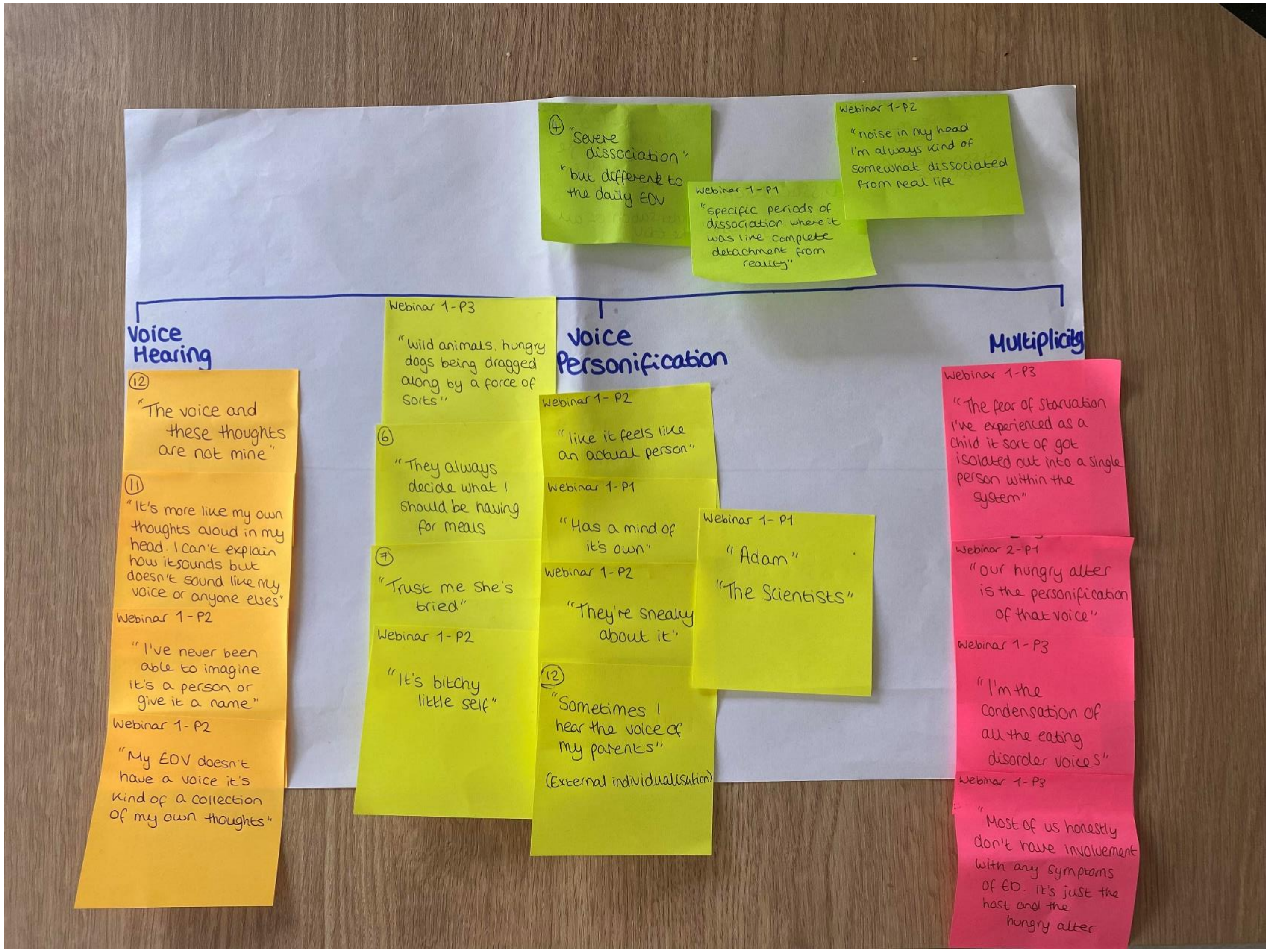
“the fear of starvation that I’ve experienced as a child it sort of got isolated out into a single person within the system”

“our hungry alter is the personification of that voice”

“I’m the condensation of all the eating disorder voices”

“Most of us honestly don’t have involvement with any symptoms of ED. It’s just the host and the hungry alter”

**Figure E2: Photo of Initial Data Analysis of the Continuum**



④ "Severe dissociation" "but different to the daily EDV

Webinar 1 - P1
"specific periods of dissociation where it was line complete detachment from reality"

Webinar 1 - P2
"noise in my head I'm always kind of somewhat dissociated from real life

Voice Hearing

⑫ "The voice and these thoughts are not mine"

⑪ "It's more like my own thoughts aloud in my head. I can't explain how it sounds but doesn't sound like my voice or anyone elses"

Webinar 1 - P2
"I've never been able to imagine it's a person or give it a name"

Webinar 1 - P2
"My EDV doesn't have a voice it's kind of a collection of my own thoughts"

Webinar 1 - P3
"wild animals, hungry dogs being dragged along by a force of sorts"

⑥ "They always decide what I should be having for meals

⑦ "Trust me she's tried"

Webinar 1 - P2
"It's bitchy little self"

Voice Personification

Webinar 1 - P2
"like it feels like an actual person"

Webinar 1 - P1
"Has a mind of it's own"

Webinar 1 - P2
"They're sneaky about it"

⑫ "Sometimes I hear the voice of my parents"
(External individualisation)

Webinar 1 - P1
"Adam"
"The Scientists"

Multiplicity

Webinar 1 - P3
"The fear of starvation I've experienced as a child it sort of got isolated out into a single person within the system"

Webinar 2 - P1
"our hungry alter is the personification of that voice"

Webinar 1 - P3
"I'm the condensation of all the eating disorder voices"

Webinar 1 - P3
"Most of us honestly don't have involvement with any symptoms of ED. It's just the host and the hungry alter

## Appendix 2-F

## Author Guidelines for Child and Adolescent Mental Health

*Author Guidelines*

### Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 67/129 (Pediatrics); 121/156 (Psychiatry); 100/143 (Psychiatry (Social Science)); 89/131 (Psychology, Clinical).
- 7,319 institutions with access to current content, and a further 6,696 institutions in the developing world
- High international readership - accessed by institutions globally, including North America (34%), Europe (34%) and Asia-Pacific (11%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 82%
- Acceptance to Early View publication averages 5 weeks
- Simple and efficient online submission – visit http://mc.manuscriptcentral.com/camh_journal
- Early View – articles appear online before the paper version is published. Click here to see the articles currently available
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Innovations in Practice; Narrative Matters; Debate Articles.

CAMH considers the fact that services are looking at treating young adults up until the age of 25, with the evidence that brains continue to develop until the age of 25, as well as the fact that a lot of issues that affect young adults and students are also relevant and topical to older adolescents. CAMH offers a discretionary approach and will take into consideration papers that extend into young adulthood, if they are pertinent developmentally to the younger population and contribute further to a developmental perspective across adolescence and early adult years.

Authors are asked to remember that CAMH is an international journal and therefore clarification should be provided for any references that are made in submitted papers to the practice within the authors' own country. This is to ensure that the meaning is clearly understandable for our diverse readership. Authors should make their papers as broadly applicable as possible for a global audience.

**Original Articles**: Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice.

**Review Articles**: These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

**Short Research Articles:** Short Research Articles should consist of original research of any design that presents succinct findings with topical, clinical or policy relevance. For example, preliminary novel findings from pilot studies, important extensions of a previous study, and topical surveys.

**Letters to the Editor:** These are short articles that offer readers the opportunity to respond to articles published in CAMH. Letters must only discuss issues directly relevant to the content of the original article such as to add context, correction, offer a different interpretation, or extend the findings.

**Innovations in Practice**: These papers report on any new and innovative development that could have a major impact on evidence-based practice, intervention and service models.

**Narrative Matters**: These papers describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences.

**Debate Articles:** These papers express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice.

**Technology Matters:** These papers provide updates on emerging mental health technologies and how they are being used with and by children and young people.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: http://mc.manuscriptcentral.com/camh_journal and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from the Editorial Office at ACAMH (email: publications@acamh.org)

4. Authors' professional and ethical responsibilities

*Disclosure of interest form*

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

*Ethics*

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

*Informed consent and ethics approval*

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

*Preprints*

CAMH will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article. Please find the Wiley preprint policy here.

*Note to NIH Grantees*

Pursuant to NIH mandate, Wiley-Blackwell will post the accepted version of contributions authored by NIH grant-holders to PubMed Central upon acceptance. This accepted version will be made publicaly available 12 months after publication. For further information, see www.wiley.com/go/nihmandate.

*Recommended guidelines and standards*

The Journal requires authors to conform to CONSORT 2010 (see CONSORT Statement) in relation to the reporting of randomised controlled clinical trials; also recommended is the Extensions of the CONSORT Statement with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials must be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry
Clinical Trials
Netherlands Trial Register
ISRCTN Registry
UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the PRISMA Statement. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis, as well as a completed PRISMA Checklist. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields and on quasi-experimental http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research and mixed method designs http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond

*CrossCheck*
An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

*Summary:* Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

*Key Practitioner Message:* Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?

- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

*Keywords:* Please provide 4-6 keywords use MeSH Browser for suggestions

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

*Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

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# Section Three: Critical Appraisal

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Within this paper, I aim to complement the earlier sections of the thesis by providing supplementary details and reflections on the research process, findings, and considerations for future research. I will first provide a summary of the findings of the systematic literature review (SLR) and the empirical research paper and discuss their implications in relation to one another. Following this, I will explore the rationale for implementing adjusted methodologies within my thesis. I will also offer a critical reflection on the research process, discussing the challenges that arose throughout. Finally, strengths and limitations of the research study will be identified, along with areas of future research within this field. By offering my personal reflections of conducting this research I hope to provide insight into the process of collaborative research design and the importance of listening to the stories of unheard populations. For a glossary of key terms see Appendix A.

## Summary of Findings

The SLR explored the effectiveness of interpersonal and relational based interventions in the treatment of eating disorders (ED). Two prominent interventions were highlighted through an abridged synthesis without meta-analysis (SWiM) of 22 quantitative studies – Interpersonal Psychotherapy (IPT) and Compassion Focused Therapy (CFT). The findings demonstrated that these interventions effectively reduced ED symptomology, producing comparable treatment outcomes to Cognitive Behavioural Therapy (CBT). Additionally, participants receiving IPT experienced a more stable recovery following the cessation of treatment. The mechanisms that underpin IPT and CFT were discussed, as these interventions directly address maintaining factors within the self, including low self-compassion and self-esteem that contribute to an individual’s reliance on ED behaviours to cope with difficulties. The relevance of clinical psychology was considered in relation to these findings and potential directions for future research were identified including: (1) further research on the long-term outcomes of IPT and CFT to solidify the evidence bases and demonstrate how they may address the significant risk of relapse affecting the ED population, (2) the implementation of realist methods within future research to understand how an intervention works, why and for whom, and (3) research addressing the Eating Disorder Voice (EDV) within interpersonal and relational based ED treatments.

The empirical research paper explored how multiplicity and voice personification are experienced by young women who report the presence of an eating disorder voice, self, or part to understand the relationship between these multisensory experiences. Through an Experience-based Co-design (EBCD) methodology, 11 participants' stories were heard. Following narrative analysis, three chapters emerged: (1) A Continuum of the EDV experiences, (2) Conflict between the Self and the EDV, and (3) The Role of an EDV in the Maintenance of an ED. The findings indicated a continuum of EDV experiences from voice-hearing to the embodiment of an EDV within a system of multiple selves, and the impact the position on this continuum has on the relationship with the EDV and recovery from an ED. Furthermore, the narratives demonstrated how their EDVs maintained their EDs including a loss of sense of self and feeling unable to let go of their EDV, which contributed to participants experiencing recovery as threatening. Implications for addressing the EDV directly within ED treatments were discussed and suggestions made for how future research can continue to include the multiplicity community to ensure these treatment pathways represent the whole continuum of EDV experiences.

Although the two sections of the thesis differ in their focus, similarities can be drawn from their findings and subsequent implications. For example, the accounts heard within the empirical research paper demonstrates how an EDV maintains an ED, while the SLR highlights potential interpersonal and relational-based interventions that may be effective in addressing these underlying maintenance factors, as IPT could address the loss of individual's sense of self, and CFT may foster a compassionate relationship with the EDV to reduce its perceived power.

Together these papers bring new perspectives on current ED interventions to address the biggest problems facing the ED population – risk of relapse and subsequent mortality. Individuals living with an ED are 5.35 times more at risk of mortality from malnutrition and suicide (Fichter &

Quadflieg, 2016; Iwajomo et al., 2021; Mitchell & Crow, 2006), which is reflected in both male and female populations (Fichter et al., 2021). There is a paucity of research representing mortality rates of EDs within transgender and non-binary populations however, it has been recorded that the risk of mortality from suicide is significantly higher within this cohort (Duffy et al., 2019). Overall, it is estimated that 3.3 million healthy life years are lost worldwide due to EDs (van Hoeken & Hoek, 2020), therefore research focused on how EDs are maintained and improving current ED treatment pathways are essential within this field. Based upon the findings from my two studies, I would recommend the following priorities for clinical psychology in this field: (1) the development of a thorough assessment tool to establish where on the continuum an individual's EDV experience lies and what intervention would be most beneficial, (2) the implementation of effective relational and interpersonal interventions, including voice dialogue therapy, IPT and CFT, that address the individual's sense of self and underlying relationship with the EDV within ED treatment and (3) further collaboration with persons with lived experience within the development process to ensure assessments and interventions are effective across the continuum of EDV experiences.

## Adapting Methodologies

A common theme within the process of my thesis were decisions surrounding the adaption of implemented methodologies to effectively answer the proposed research questions. Within clinical practice, clinical psychologists readily adapt interventions to create a person centred and tailored approach, therefore we can employ similar skills to adapt methods in research to ensure more meaningful and engaging inclusive research practices. I adapted a SWiM and EBCD methodology to good effect for the research questions I addressed, which are discussed here.

### *SLR: SWiM*

A narrative synthesis within the context of a SLR synthesises the reported effects within the selected papers through a textual approach (Popay et al., 2006). However, there is limited guidance on conducting syntheses that do not utilise a meta-analysis of effect estimates. As a result, papers reporting this approach lack descriptions of how the synthesis was completed, lack evidence of transparent links between studies data, the report of the synthesis and the conclusions drawn from it (Campbell et al., 2019). Therefore, the SWiM methodology (Campbell et al., 2020) was beneficial compared to this approach as it provides a guideline that ensures complete and transparent reporting of the method of synthesis and subsequent results.

When conducting the SLR I explored various synthesis method options, including combining P-values and completing a vote count of direction of effects of the included papers. However, within supervision, we explored whether these analytic stages were essential to the transparency of reporting as they fell beyond the scope of a synthesis within an SLR for a DClinPsy thesis. Therefore, I decided to adapt a SWiM analysis. The initial guidance regarding grouping studies and establishing a standardised metric used within the papers was followed, then a narrative synthesis was conducted, and the reporting was informed by the quality assessment process and in line with the SWiM guidelines. The adaption of my methodological approach resulted in transparent reporting of the synthesis undertaken that allows for this SLR to be replicated in the future. Furthermore, this process increased my confidence in understanding, selecting, and adapting appropriate research methodologies as a researcher.

### *Empirical Study: EBCD*

The EBCD methodology was originally created to co-design services and pathways in collaboration with service users and persons with lived experience (Point of Care Foundation, n.d.). The process involves collating the stories of those with lived experience and staff, gathered through interviews or group discussions, into a short stimulus film which is presented back to the development group. This group then allows experts by experience and staff to collaboratively identify and implement service development improvements (Point of Care Foundation, n.d.). This person-centred approach aims to improve service user experience (Bate & Robert, 2023) while also encouraging organisations to review their processes and systems from a person-centred perspective (Gustavsson, 2014).

The EBCD approach is beginning to be adapted within research methodologies, in particular within health-care settings (Raynor et al., 2020; Flyan et al., 2021) and to reach marginalised populations (Girling et al., 2022). Therefore, to implement the EBCD principles within clinical psychology research similar adaptions were needed, specifically the inclusion of a layered data collection process centred on participant's collaboration and feedback on the interpretation of data prior to a finalised analysis.

Within my study, similar to the original approach, stories from persons with lived experience were gathered and held central throughout the process. However, unlike other qualitative designs, EBCD methodology is grounded on collaboration, thus while designing this study I wanted to ensure participants were able to provide feedback to our interpretations of their stories. A 3-layered data collection approach was subsequently designed which allowed us as researchers to create space to present the emerging narrative themes to participants and hear whether their experiences had been accurately represented.

There were several benefits of implementing this design over traditional semi-structured interviews. Firstly, giving participants the freedom to narrate their own stories in a creative medium of their choice ensured their experiences were not confined by a pre-determined question prompts and subsequently allowed for an inductive data analysis approach. Secondly, this methodology enabled me to minimise the risk of academic ventriloquism (Silverio et al., 2022). This concept explores the power held by researchers to elevate particular participants' voices, while silencing others at different stages of conducting research, including analysis, interpretation, and reporting (Kristensen & Ravn, 2015). By doing so, researchers can "throw" their own voices, to give the impression of participants' voices being heard, when in fact the "voice" presented is of the researcher interpreting the participants' voices. Therefore, by adapting the EBCD methodology, instead of implementing traditional qualitative designs, it ensured participants' voices were appropriately included and represented within the empirical paper whilst encouraging me to exercise reflexivity during the process of data collection and analysis.

## Ethical Considerations Surrounding Multiplicity

Whilst conducting this research, the ethical challenge of ensuring an appropriate process for obtaining informed consent from participants experiencing multiplicity was considered. Informed consent allows participants to make the decision to participate in research following being provided with information regarding all aspects of their involvement and the intention of the research (Nijhawan et al., 2013). However, as different members of a system may hold different opinions, values and preferences, there was potential for difficulties to arise surrounding obtaining informed consent from a system.

Prior to the second layer of data collection, the initial online group, my supervisors and I explored how to manage potential difficulties including, if one member of a system withdrew consent and if a different alter began fronting during discussions. It was agreed that we'd obtain consent for the system to participate from the host and follow the guidance within Eve and Parry (2021) to address this topic through conversations with the participants at the beginning of the online discussion. Thus, as part of my introductions to the online group, which included keeping themselves safe during the discussion, I acknowledged the process of obtaining and withdrawing their consent from the research in the context of multiplicity – no concerns were raised from participants, who consented on behalf of their systems. In hindsight, this process could have been improved through adapting the language included in the consent forms, as these potential barriers were not considered until after ethical approval had been given and the consent forms generated. Therefore, the inclusion of consent-based questions which addressed these ethical challenges such as "I, the host, agree on behalf of my system to participate in this study" would have added further clarity to this process.

## Recruitment Challenges and Solutions

Initially, the participant’s stories submitted within data collection layer one were due to undergo preliminary analysis so emerging narratives could be presented in the online discussion within layer two, as this would form the collaborative feedback process of EBCD. However, despite consistent engagement with our social media posts it proved difficult to recruit participants to the initial stage of this research project. It was then decided to adapt the research study’s design to allow further stories to be captured within the first online group and to utilise the final online group to provide the feedback process. To do this, additional funding was utilised to invite an illustrator, Emma Paxton, to the online group to visually capture the participants’ stories. Alongside this, participants who expressed interest in attending the online group were asked if they’d also like to submit their story. This amendment was submitted and approved by the Research Ethics Committee. Upon reflection, the open-endedness of layer one of our research, which we perceived to allow participants flexibility to express their story in their own way and within their own time, may have been perceived as daunting or induced a fear of “getting it wrong”. A recent literature review demonstrated that ED symptoms were associated with higher levels of perfectionism within children and adolescents (Bills et al., 2023), a construct that contributes to high personal standards and concern of making mistakes (Frost et al., 1990). Therefore, it may have been beneficial to provide optional prompts or questions such as “How would you represent your experience of living with an EDV” to help overcome this anxiety while also not placing constraints on the requirements of their stories.

Alongside this, a further question was raised by a prospective participant, during the recruitment phase, regarding the inclusion criteria of the research study. They were a transgender male who experienced multiplicity with a female member of their system that experienced eating difficulties and they were asking for clarity of whether they met the inclusion criteria – which at the time simply stated, “people who identify as female”. Within supervision we discussed and reviewed the aim of the research and agreed that to explore this experience within a multiplicity population the gender inclusion criteria would apply to both hosts and the members within the system. Therefore, the language used within the inclusion criteria was altered to reflect this and add clarity – "either the host or body can be female identifying, or the headmate/source, within the system, who experiences the ED behaviours can be female identifying". Personally, this felt like an oversight during the design process, which meant language which did not represent the population was used. In future studies within this field, it may be beneficial to collaboratively work with experts by experience during the design phases for example, use of language within consent forms, designing recruitment advertisements and identifying appropriate social media sites and platforms. Their involvement within the earlier stages of research studies would align with the collaborative principles of the EBCD methodology.

## Reflexivity and Transparency within Narrative Analysis

Whilst conducting this research, it was important for me to acknowledge my position, opinions and perspectives within my role as the researcher, and appraise the impact this has on data collection and analysis through reflexivity (Finlay, 2002b). Olmos-Vega et al. (2023) defines reflexivity as "a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise and evaluate how their subjectivity and context influence the research processes". Prior to commencing the data collection, I was aware superficially that I have no personal experience nor know anyone who has lived with an ED, voice-hearing or multiplicity. However, when reflecting on my wider context it is important for me to acknowledge that I am female identifying and hold my own experience of the impact of hearing negative commentary towards body shape, weight and eating behaviours within my personal life and through the media. I feel this shared experience of female-identifying people may have aided participants to feel able to entrust their stories with me as a researcher, yet a lack of personal experience allowed me to approach the research without preconceived assumptions and instead act as a vehicle for the expression of the participant’s stories. As the research progressed, I felt a growing sense of responsibility to do the stories entrusted to me justice by preserving the raw emotions I’d heard within the writing of the empirical paper. This was further reinforced by the retention of participants throughout the layers of data collection as rapport with participants was built and their continued passion to be involved within this research was evident.

A contemporary approach to reflexivity, is that attempts to erase subjectivity through neutralisation or acknowledgement are futile and detrimental to the research as it is the product of all human interactions. Therefore, subjectivity should be considered integral to the research process (Finlay, 2002a; Koopman et al., 2020). This approach has the perspective that a researcher’s subjectivity can be actively used within research to co-construct data and findings within collaborative participatory methodologies, such as EBCD. In methodologies where participants are given a more active role they too can be considered as reflexive (Bergold & Thomas, 2012), with the collaborative dialogue between the parties encouraging the researcher to address bias, adjust, and refine their interpretations accordingly (Smith, 1994). In summary, by implementing an EBCD approach within this research it allowed the inevitable subjectivity to be effectively addressed through feedback directly from participants which may subsequently enhance the reflexivity in this qualitative methodology.

## Strengths, Limitations, and Future Research

An interesting observation during the data analysis process was the change in language used within the online discussions by one participant, who participated in all three layers of the project. In the first online discussion they disclosed their experience of multiplicity to the group and used imagery with animalistic connotations “like if you had a dog that’s way too strong on a leash” to describe their experience of living with an EDV. Yet, in the follow-up online discussion the imagery and language used to describe the EDV became more detailed “I have a starry red fox monster in my head”. It could be argued that the participant’s multiplicity explains this shift in language, as different members of the system could be fronting within the two discussions and therefore are providing alternative perspectives on their experience of an EDV. However, due to the first online discussion being compromised of participants with varied voice-hearing experiences compared to the solely multiplicity sample of the final online group, it is potentially more likely that stigma contributed to this noticeable shift in language.

Stigma is a recurrent character present within the narratives of multiplicity. Previous qualitative research has demonstrated that external stigma from family, friends and professionals is a common experience for this population and contributes to anxiety surrounding disclosing their experiences due to fear of rejection from others (Fox et al., 2013; Ribáry et al., 2017). An experience echoed by the stories heard within this research. Furthermore, this stigma is present more broadly within our wider society due to a lack of understanding and exaggerated inaccurate representations of multiplicity within media portrayals (Floris & McPherson, 2015; Parry et al., 2022). Therefore, this participant may have felt the need to be more guarded within the initial online group utilising imagery that they felt was accessible to the audience whereas they were later able to tell their story in an unaltered manner within the safety of a multiplicity focused discussion. Thus, highlighting a strength of the EBCD design of this research, as this additional rich narrative would not have been heard if the feedback process of a follow-up online discussion was not completed. Future research may therefore benefit from considering an EBCD approach when gathering stories from a heterogenous sample, especially when including populations that are highly stigmatised. This methodology approach enables participants to feel valued and heard and enables researchers to build a sense of safety within the participation process as the clearly defined feedback processes ensures the identified narratives within the data analysis accurately represent the stories shared.

A further strength of the research design was conducting the discussions groups online. An online format allows for, geographical limits to be lifted to promote worldwide engagement, verbal and text-based contributions to discussions via chat functions, which was utilised by several participants throughout the groups, and an accessible platform for those with physical disabilities (Carter et al., 2021; Hewson, 2014). However, online focus groups can present challenges including; exclusion of individuals without access to reliable internet connections or those who do not feel competent to use technology, online platforms can be less accessible to specific disabilities e.g. hearing impairments, a lack of safety if participants become distressed and a difficulty reading body language and nonverbal cues via video-call (Carter et al., 2021; Seitz, 2016). Within these papers they highlight recommendations to overcome barriers to online qualitative data collection such as, implementing a distress protocol, deciding a designated facilitator to provide emotional support to participants, and minimising the number of participants to a maximum of six. These recommendations were all implemented within this research study. To further aid a sense of safety within the group, it may have been beneficial to complete pre-group checks ins with participants to answer questions regarding their participation and begin to build a rapport. Further research should consider these practical and methodological issues when conducting qualitative research online and make appropriate adaptions to meet the needs of the intended population. One recommendation may be to include within the consent form a space for participants to state any additional needs that may facilitate their engagement to ensure online discussion groups or interviews can be person-centred.

It is important to acknowledge that the empirical paper’s findings cannot be extrapolated to all individuals who experience or access support for an ED. Although the sample of participants includes a population likely to live with an ED, young women, and provides insightful accounts to advance our understanding of the EDV for this group, it does not represent other populations such as those who identify as males, transgender, or non-binary. The prevalence rate of men experiencing an ED has increased exponentially in recent decades (Lyons et al., 2019), with recent estimates of EDs present in 0.6-2.4% of young men (Silén & Keski-Rahkonen, 2022). However, as only 16% of men living with an ED will seek treatment due to stigmatisation (Freeman, 2005; Soban, 2006), it is likely that current figures are underestimating the actual prevalence rates. Additionally, there is an elevated risk of developing an ED in transgender and gender diverse populations (Gordon et al., 2021), in particular transgender men (Diemer et al., 2018; Simone et al., 2022). Thus, a ramification of including only young women in the current research study is that we cannot imply the presence of the continuum of the EDV experience within the excluded populations. Therefore, future research may benefit from continuing exploration of multiplicity, voice personification and the EDV within men and gender diverse individuals to ensure potential interventions to address the EDV are tailored to be effective for each individual accessing support for an ED. Although continued research within this field is essential, this thesis makes a unique and timely contribution to clinical psychology by furthering understanding of the EDV phenomena as a continuum and highlighting the importance of addressing the EDV within ED treatment to improve the rates of recovery.

## Conclusions

To conclude, this thesis is the first to explore the relationship between seemingly distinct multisensory experiences within the ED population. It is hoped that the insights outlined in this thesis inform future research to continue to build towards effective interventions that can address the devasting reality of the mortality and relapse rates within ED treatment. The critical appraisal paper aimed to highlight methodological adaptions implemented during the development of the research study alongside practical and ethical issues that arose and were addressed within the process. These reflections are intended to provide future research with insight into considerations necessary to conducting research with multiplicity and ED populations. Finally, this thesis has demonstrated not only the benefits and possibilities of implementing an EBCD methodology but the importance of elevating the voices of unheard populations within qualitative research.

# References

Bate, P., & Robert, G. (2023). *Bringing user experience to healthcare improvement: the concepts, methods and practices of experience-based design*. CRC Press.

Bergold, J., & Thomas, S. (2012). Participatory research methods: A methodological approach in motion. *Historical Social Research/Historische Sozialforschung*, 191-222.

Bills, E., Greene, D., Stackpole, R., & Egan, S. J. (2023). Perfectionism and eating disorders in children and adolescents: A systematic review and meta-analysis. *Appetite*, 106586.

Campbell, M., Katikireddi, S. V., Sowden, A., & Thomson, H. (2019). Lack of transparency in reporting narrative synthesis of quantitative data: a methodological assessment of systematic reviews. *Journal of clinical epidemiology*, *105*, 1-9.

Campbell, M., McKenzie, J. E., Sowden, A., Katikireddi, S. V., Brennan, S. E., Ellis, S., Hartmann-Boyce, J., Ryan, R., Shepperd, S., & Thomas, J. (2020). Synthesis without meta-analysis (SWiM) in systematic reviews: reporting guideline. *bmj*, *368*.

Carter, S. M., Shih, P., Williams, J., Degeling, C., & Mooney-Somers, J. (2021). Conducting qualitative research online: challenges and solutions. *The Patient-Patient-Centered Outcomes Research*, *14*(6), 711-718.

Diemer, E. W., White Hughto, J. M., Gordon, A. R., Guss, C., Austin, S. B., & Reisner, S. L. (2018). Beyond the binary: differences in eating disorder prevalence by gender identity in a transgender sample. *Transgender Health*, *3*(1), 17-23.

Duffy, M. E., Henkel, K. E., & Joiner, T. E. (2019). Prevalence of self-injurious thoughts and behaviors in transgender individuals with eating disorders: a national study. *Journal of Adolescent Health*, *64*(4), 461-466.

Eve, Z., & Parry, S. (2021). Exploring the experiences of young people with multiplicity. *Youth and Policy*.

Fichter, M. M., Naab, S., Voderholzer, U., & Quadflieg, N. (2021). Mortality in males as compared to females treated for an eating disorder: a large prospective controlled study. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, *26*, 1627-1637.

Fichter, M. M., & Quadflieg, N. (2016). Mortality in eating disorders-results of a large prospective clinical longitudinal study. *International Journal of Eating Disorders*, *49*(4), 391-401.

Finlay, L. (2002a). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209-230.

Finlay, L. (2002b). “Outing” the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531-545.

Floris, J., & McPherson, S. (2015). Fighting the whole system: Dissociative identity disorder, labeling theory, and iatrogenic doubting. *Journal of Trauma & Dissociation*, *16*(4), 476-493.

Fox, J., Bell, H., Jacobson, L., & Hundley, G. (2013). Recovering identity: A qualitative investigation of a survivor of dissociative identity disorder. *Journal of Mental Health Counseling*, *35*(4), 324-341.

Freeman, A. C. (2005). Eating disorders in males: A review. *South African Psychiatry Review*, *8*(2), 58-64.

Frost, R. O., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive therapy and research*, *14*, 449-468.

Fylan, B., Tomlinson, J., Raynor, D. K., & Silcock, J. (2021). Using experience-based co-design with patients, carers and healthcare professionals to develop theory-based interventions for safer medicines use. *Research in Social and Administrative Pharmacy*, *17*(12), 2127-2135.

Girling, M., Le Couteur, A., & Finch, T. (2022). Experience-based co-design (EBCD) with young people who offend: Innovating methodology to reach marginalised groups. *PloS one*, *17*(7), e0270782.

Gordon, A. R., Moore, L., & Guss, C. (2021). Eating disorders among transgender and gender non-binary people. *Eating disorders in boys and men*, 265-281.

Gustavsson, S. (2014). Improvements in neonatal care; using experience-based co-design. *International journal of health care quality assurance*, *27*(5), 427-438.

Hewson, C. (2014). Qualitative approaches in internet-mediated research: Opportunities, issues, possibilities. *The Oxford handbook of qualitative research*, *21*.

Iwajomo, T., Bondy, S. J., de Oliveira, C., Colton, P., Trottier, K., & Kurdyak, P. (2021). Excess mortality associated with eating disorders: population-based cohort study. *The British Journal of Psychiatry*, *219*(3), 487-493.

Koopman, W. J., Watling, C. J., & LaDonna, K. A. (2020). Autoethnography as a Strategy for Engaging in Reflexivity. *Global Qualitative Nursing Research*, *7*, 2333393620970508.

Kristensen, G. K., & Ravn, M. N. (2015). The voices heard and the voices silenced: Recruitment processes in qualitative interview studies. *Qualitative Research*, *15*(6), 722-737.

Lyons, G., McAndrew, S., & Warne, T. (2019). Disappearing in a female world: Men’s experiences of having an eating disorder (ED) and how it impacts their lives. *Issues in Mental Health Nursing*, *40*(7), 557-566.

Mitchell, J. E., & Crow, S. (2006). Medical complications of anorexia nervosa and bulimia nervosa. *Current Opinion in Psychiatry*, *19*(4), 438-443.

Nijhawan, L. P., Janodia, M. D., Muddukrishna, B., Bhat, K. M., Bairy, K. L., Udupa, N., & Musmade, P. B. (2013). Informed consent: Issues and challenges. *Journal of advanced pharmaceutical technology & research*, *4*(3), 134.

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical teacher*, *45*(3), 241-251.

Parry, S., Eve, Z., & Myers, G. (2022). Exploring the utility and personal relevance of co-produced multiplicity resources with young people. *Journal of Child & Adolescent Trauma*, 1-13.

Point of Care Foundation. (n.d). *EBCD: Experience-based Co-design toolkit.* Retrieved January 5 2023 from https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*(1), b92.

Raynor, D. K., Ismail, H., Blenkinsopp, A., Fylan, B., Armitage, G., & Silcock, J. (2020). Experience-based co-design—adapting the method for a researcher-initiated study in a multi-site setting. *Health Expectations*, *23*(3), 562-570.

Ribáry, G., Lajtai, L., Demetrovics, Z., & Maraz, A. (2017). Multiplicity: An explorative interview study on personal experiences of people with multiple selves. *Frontiers in Psychology*, *8*, 938.

Seitz, S. (2016). Pixilated partnerships, overcoming obstacles in qualitative interviews via Skype: A research note. *Qualitative Research*, *16*(2), 229-235.

Silén, Y., & Keski-Rahkonen, A. (2022). Worldwide prevalence of DSM-5 eating disorders among young people. *Current Opinion in Psychiatry*, *35*(6), 362-371.

Silverio, S. A., Wilkinson, C., & Wilkinson, S. (2022). Academic ventriloquism: Tensions between inclusion, representation, and anonymity in qualitative research. In *Handbook of social inclusion: Research and practices in health and social sciences* (pp. 643-660). Springer.

Simone, M., Hazzard, V. M., Askew, A. J., Tebbe, E. A., Lipson, S. K., & Pisetsky, E. M. (2022). Variability in eating disorder risk and diagnosis in transgender and gender diverse college students. *Annals of epidemiology*, *70*, 53-60.

Smith, J. A. (1994). Towards reflexive practice: Engaging participants as co-researchers or co-analysts in psychological inquiry. *Journal of community & applied social psychology*, *4*(4), 253-260.

Soban, C. (2006). What about the Boys?: Addressing Issues of Masculinity within. *International Journal of Men's Health*, *5*(3), 251-267.

van Hoeken, D., & Hoek, H. W. (2020). Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden. *Current Opinion in Psychiatry*, *33*(6), 521.

## Appendix 3-A

## Glossary of Key Terms

| Key Terms | Definitions | Abbreviation |
|---|---|---|
| Anorexia Nervosa | An eating disorder characterised by the restriction of energy intake relative to requirements leading to a significantly low body weight | |
| Behavioural Weight Loss | A behavioural based intervention focused on changing eating and exercise habits to lose weight | BWL |
| Binge Eating Disorder | An eating disorder characterised by recurrent episodes of binge eating. | |
| Bulimia Nervosa | An eating disorder characterised by recurrent episodes of binge eating and compensatory behaviours to prevent weight gain | |
| Cognitive Analytic Therapy | A psychological therapy that focuses on relationship patterns | CAT |
| Cognitive Behavioural Therapy | A psychological therapy that focuses on changing thoughts and behaviours | CBT |
| Compassion Focused Therapy | A psychological therapy that focused on shame and self-criticism through developing skills of compassion to self and others | CFT |
| Complex Voice Personification | A category of voice personification where the voice is perceived to have more detailed characteristics that can alter e.g., intentions and actions | |
| Dialectical Behavioural Therapy | A third-wave behavioural psychological therapy that focuses on building strategies to aid emotional regulation | DBT |
| Dissociative Identity Disorder | A mental health condition where the presence of distinct multiple selves causes amnesia, distress and impaired functioning | DID |
| Eating Disorder Examination Interview | A semi-structured interview to assess the psychopathology associated with an eating disorder diagnosis | EDE-I |
| Eating Disorder Examination Questionnaire | A self-report questionnaire to assess the psychopathology associated with an eating disorder diagnosis. This measure was adapted from the Eating Disorder Examination Interview | EDE-Q |
| Eating Disorder Not Otherwise Specified | An eating disorder characterised by the presentation of symptoms that cause distress but do not meet the full criteria | EDNOS |

| | | |
|---|---|---|
| | for any of the eating disorder diagnostic class | |
| Eating Disorder Voice | The experience of hearing a voice which comments on the individual's eating patterns, body shape and weight | EDV |
| Eating Disorders | A mental health condition where the control of food is used to cope with difficult feelings and external situations. | ED |
| Educational Behavioural Treatment | A treatment which combined behavioural based approaches such as monitoring and goal setting with education about nutrition, metabolism and eating disorders | EBT |
| Experience-Based Co-Design | An approach that enables staff/clinicians/researchers and people of lived experiences to co-design services and/or treatment pathways in partnership | EBCD |
| External Individualisation | A category of voice personification where the voice heard is recognisable to the person | |
| Family Therapy | A psychological therapy that focuses on the relationships among family members | |
| Functional Narrative Analysis | A narrative analysis component that focuses on what the narrator is trying to achieve through the content and structure of their narrative | |
| Internal Individualisation | A category of voice personification where the voice heard cannot be attributed to a pre-existing known person | |
| Interpersonal Interventions | A type of interventions which focuses on interpersonal challenges and relationships | |
| Interpersonal Psychotherapy | A form of psychotherapy that focuses on addressing and improving interpersonal functioning. | IPT |
| Longitudinal Design | A study design which employs continuous or repeated measures of a sample over a prolonged period of time | |
| Minimal Voice Personification | A category of voice personification where the voice has superficial person-like characteristics e.g. age or gender | |
| Multiplicity | The experience of being more than one self, person, or identity. A system of multiple selves that share a host body | |
| Multisensory Experiences | The experience of seeing, hearing, or feeling things that aren't there | |

| | | |
|---|---|---|
| Narrative Analysis | A qualitative analysis approach that focuses on interpreting core narratives from participants into a coherent story | |
| Other Specified Feeding and Eating Disorders *(Previously known as Eating Disorder not Otherwise Specified)* | An eating disorder characterised by the presentation of symptoms that cause distress but do not meet the full criteria for any of the eating disorder diagnostic class | OSFED |
| Pseudo-hallucination | An involuntary sensory experience that is recognised by the individual as unreal or an illusion. | |
| Psychoanalytic Psychotherapy | A form of psychotherapy that focuses on addressing difficulties that can impact on relationships | |
| Psychodynamic Interpersonal Psychotherapy | A form of psychotherapy informed by psychodynamic and interpersonal theories which focused on addressing interpersonal difficulties and difficulties in their relationships with others | PIP |
| Realist Methods | A research approach which aims to identify underlying causal mechanisms of interventions and exploring how they work in different conditions | |
| Relational Interventions | A type of intervention which focuses on difficulties in the relationship with self and others | |
| Relational Therapy | A psychological therapy which focuses on patterns of relating to others. | |
| Socio-cultural Themes | Societal and cultural influences that may contribute to the formation of an individual’s narrative. | |
| Structural Narrative Analysis | A narrative analysis component focused on how the narrative is told through tonality, pacing, language and how the structure guides the listener through the narrative | |
| Synthesis Without Meta-Analysis | A synthesis methodology which uses alternative synthesis methods and promotes transparency when reporting the results | SWiM |
| Voice Dialogue | A psychological therapy which encourages clients to engage with various parts of the self through dialogue | |
| Voice Hearing Continuum | The representation of voice hearing experiences from experiences that do not require clinical intervention considered | |

| | |
|---|---|
| | “healthy voice hearers” to more pronounced clinical difficulties |
| Voice Personification | A voice hearing experience where the voice possesses person-like characteristics |

# Section Four: Ethics Section

**Phoebe Dale**

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

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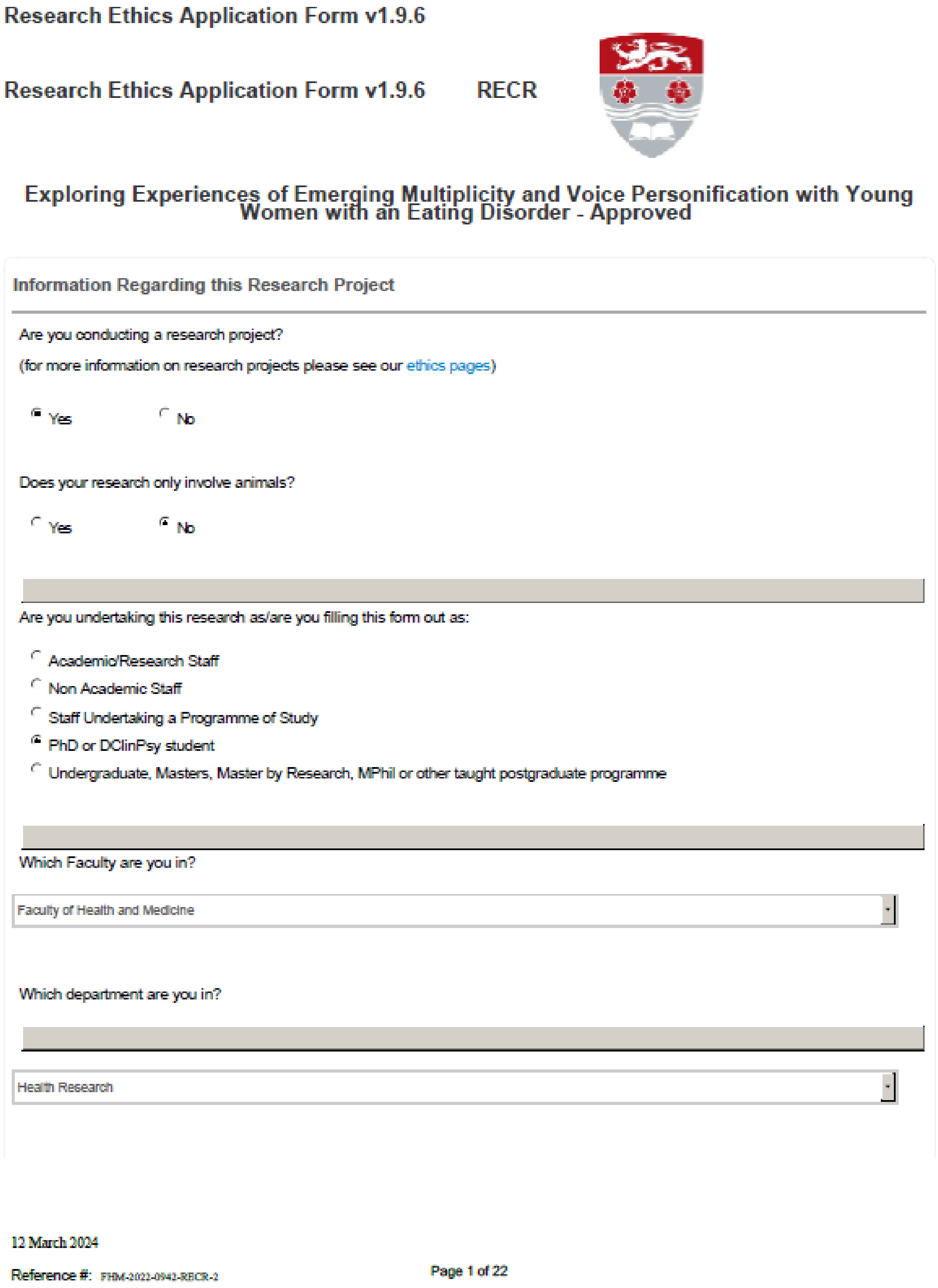


## Research Ethics Application Form v1.9.6

Research Ethics Application Form v1.9.6 RECR

## Exploring Experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder - Approved

### Information Regarding this Research Project

Are you conducting a research project?

(for more information on research projects please see our ethics pages)

● Yes ○ No

Does your research only involve animals?

○ Yes ● No

Are you undertaking this research as/are you filling this form out as:

○ Academic/Research Staff
○ Non Academic Staff
○ Staff Undertaking a Programme of Study
● PhD or DClinPsy student
○ Undergraduate, Masters, Master by Research, MPhil or other taught postgraduate programme

Which Faculty are you in?

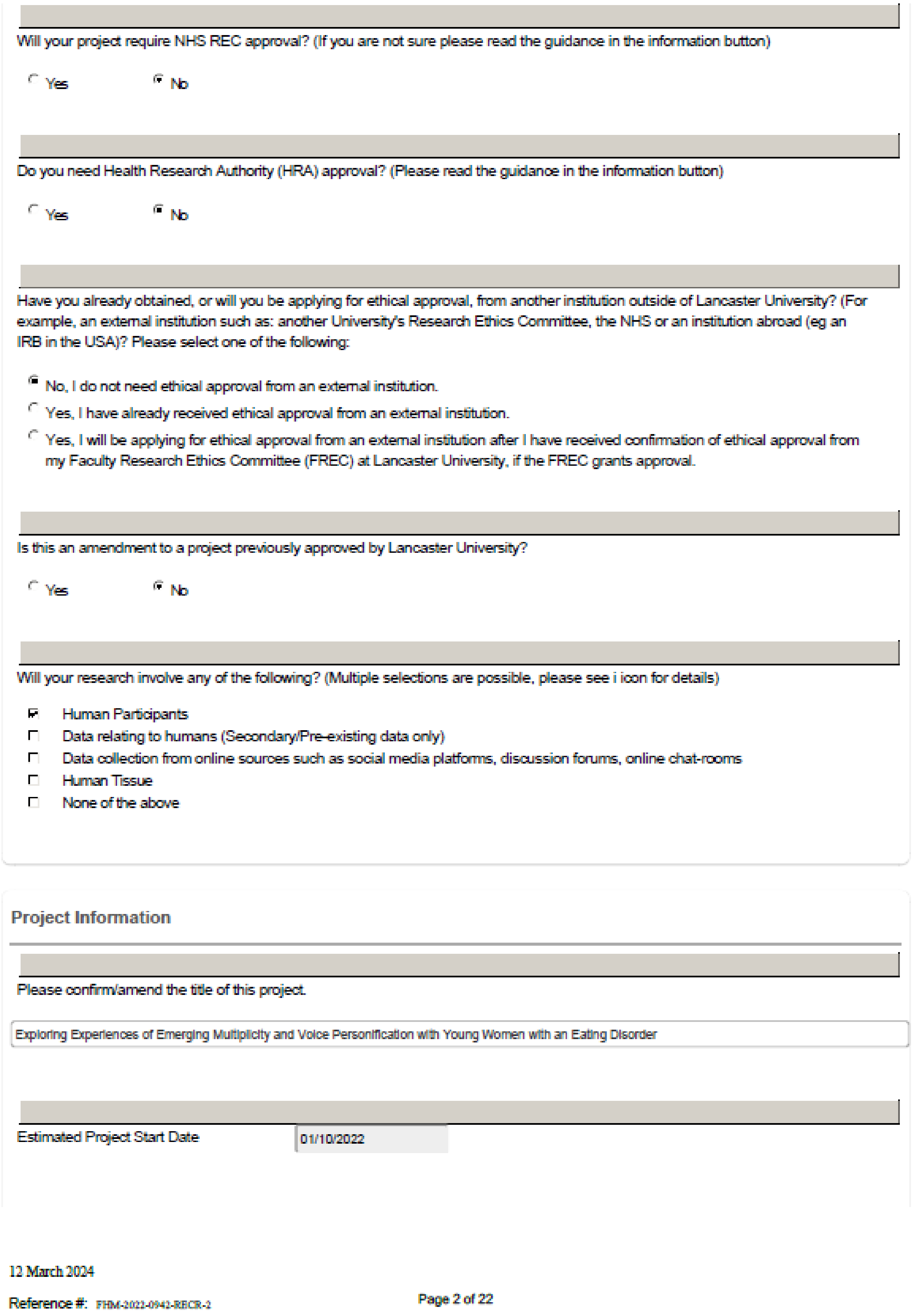
Faculty of Health and Medicine

Which department are you in?

Health Research

12 March 2024

Reference #: FHM-2022-0942-RECR-2



Will your project require NHS REC approval? (If you are not sure please read the guidance in the information button)

○ Yes ● No

Do you need Health Research Authority (HRA) approval? (Please read the guidance in the information button)

○ Yes ● No

Have you already obtained, or will you be applying for ethical approval, from another institution outside of Lancaster University? (For example, an external institution such as: another University's Research Ethics Committee, the NHS or an institution abroad (eg an IRB in the USA)? Please select one of the following:

● No, I do not need ethical approval from an external institution.
○ Yes, I have already received ethical approval from an external institution.
○ Yes, I will be applying for ethical approval from an external institution after I have received confirmation of ethical approval from my Faculty Research Ethics Committee (FREC) at Lancaster University, if the FREC grants approval.

Is this an amendment to a project previously approved by Lancaster University?

○ Yes ● No

Will your research involve any of the following? (Multiple selections are possible, please see i icon for details)

☑ Human Participants
☐ Data relating to humans (Secondary/Pre-existing data only)
☐ Data collection from online sources such as social media platforms, discussion forums, online chat-rooms
☐ Human Tissue
☐ None of the above

**Project Information**

Please confirm/amend the title of this project.

Exploring Experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder

Estimated Project Start Date 01/10/2022

12 March 2024

Reference #: FHM-2022-0942-RECR-2

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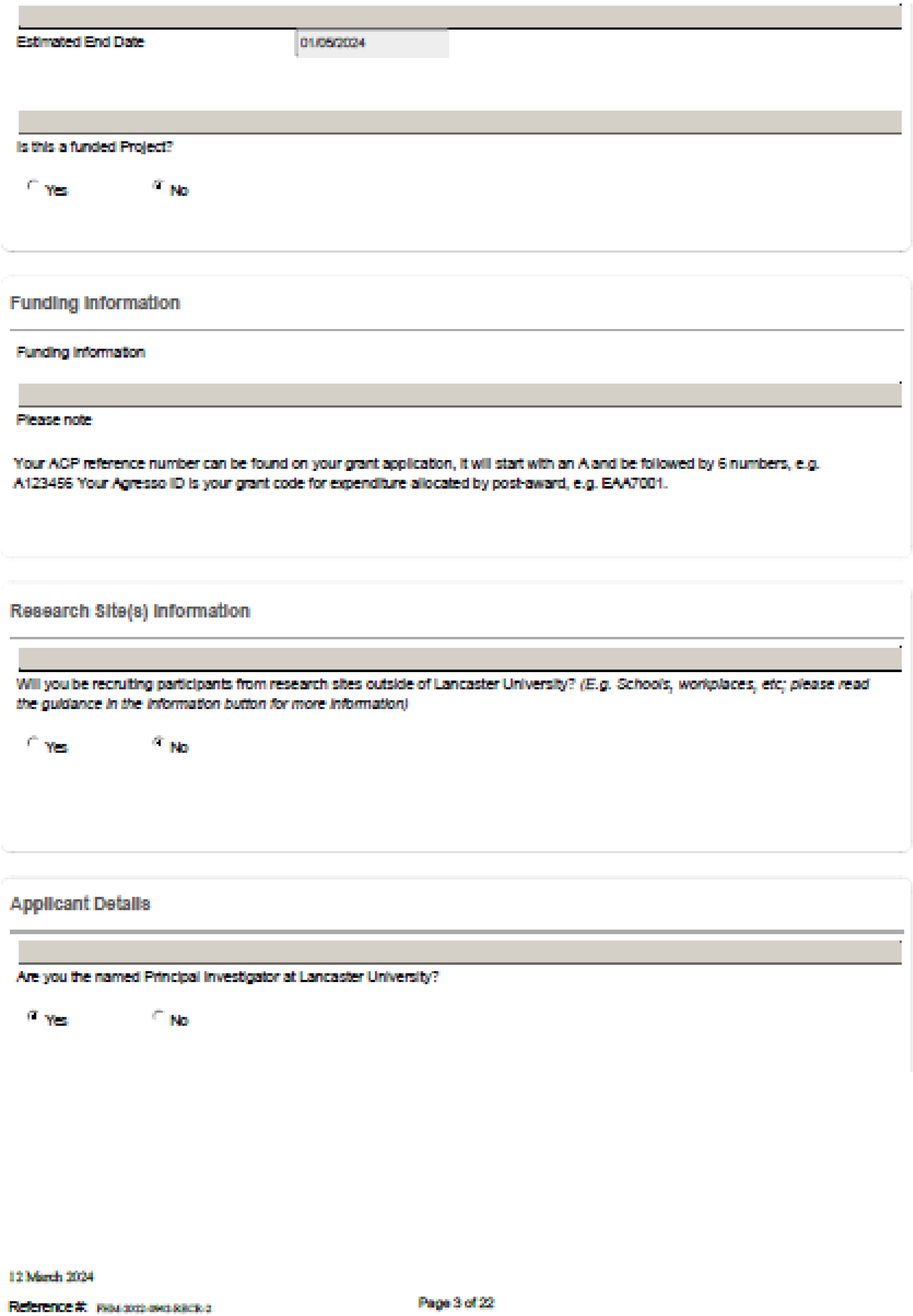

Estimated End Date 01/05/2024

Is this a funded Project?

○ Yes ● No

## Funding Information

Funding Information

Please note

Your ACP reference number can be found on your grant application, it will start with an A and be followed by 6 numbers, e.g. A123456 Your Agresso ID is your grant code for expenditure allocated by post-award, e.g. EAA7001.

## Research Site(s) Information

Will you be recruiting participants from research sites outside of Lancaster University? *(E.g. Schools, workplaces, etc; please read the guidance in the information button for more information)*

○ Yes ● No

## Applicant Details

Are you the named Principal Investigator at Lancaster University?

● Yes ○ No

12 March 2024

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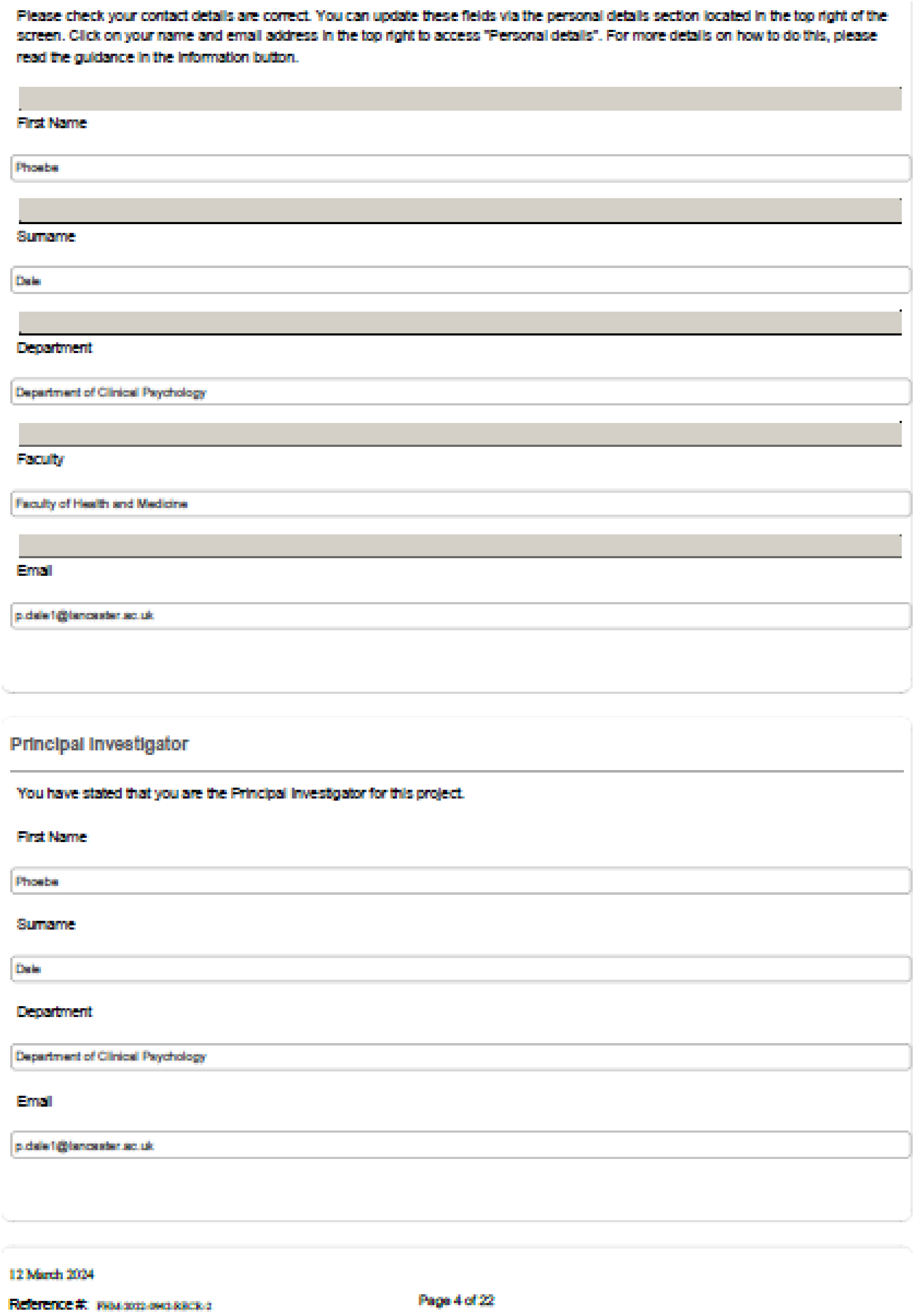

Please check your contact details are correct. You can update these fields via the personal details section located in the top right of the screen. Click on your name and email address in the top right to access "Personal details". For more details on how to do this, please read the guidance in the information button.

First Name

Phoebe

Surname

Dale

Department

Department of Clinical Psychology

Faculty

Faculty of Health and Medicine

Email

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## Principal Investigator

You have stated that you are the Principal Investigator for this project.

First Name

Phoebe

Surname

Dale

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Department of Clinical Psychology

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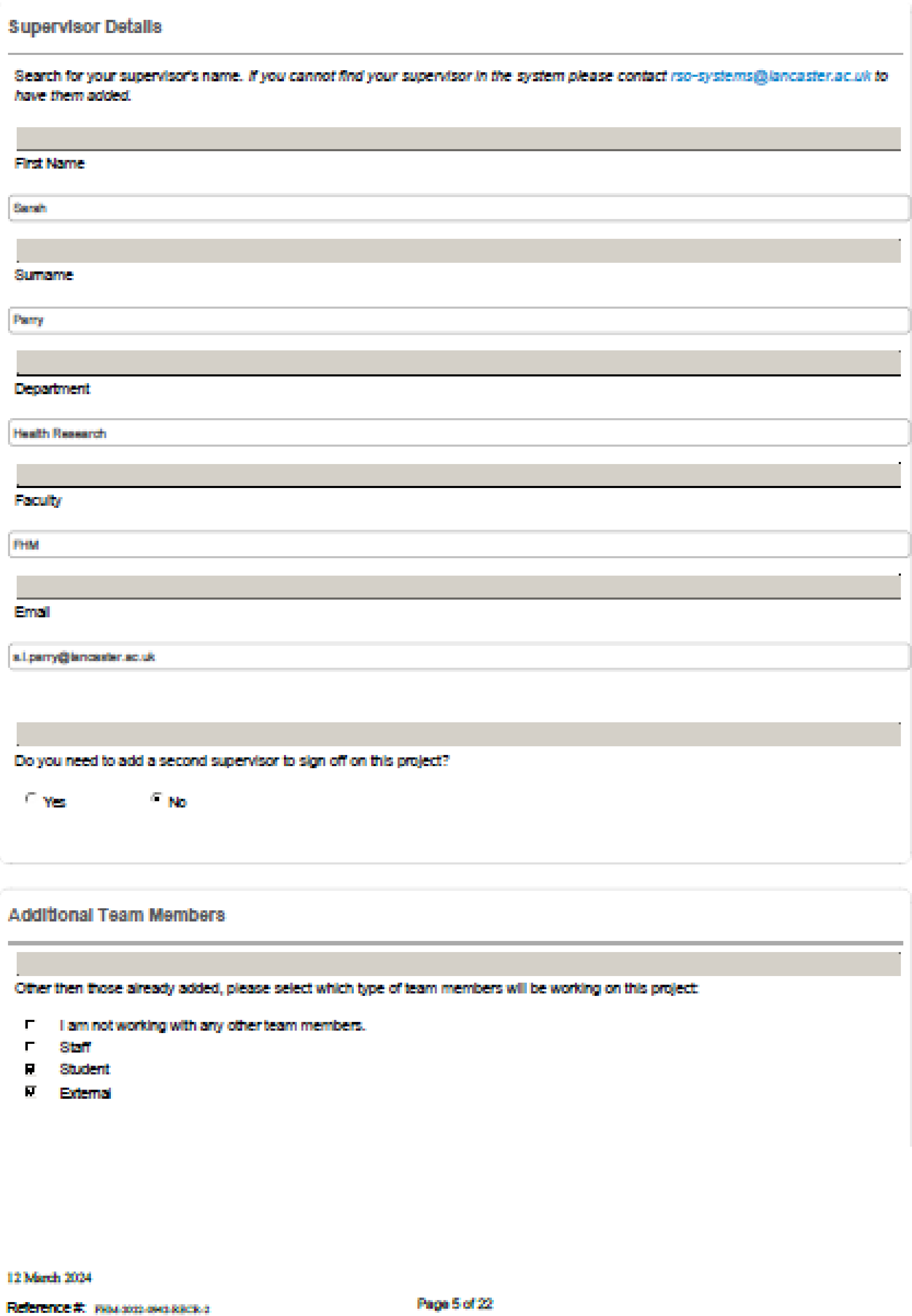

## Supervisor Details

Search for your supervisor's name. *If you cannot find your supervisor in the system please contact rso-systems@lancaster.ac.uk to have them added.*

First Name

Sarah

Surname

Parry

Department

Health Research

Faculty

FHM

Email

s.l.parry@lancaster.ac.uk

Do you need to add a second supervisor to sign off on this project?

○ Yes ● No

## Additional Team Members

Other then those already added, please select which type of team members will be working on this project:

- ☐ I am not working with any other team members.
- ☐ Staff
- ☑ Student
- ☑ External

12 March 2024

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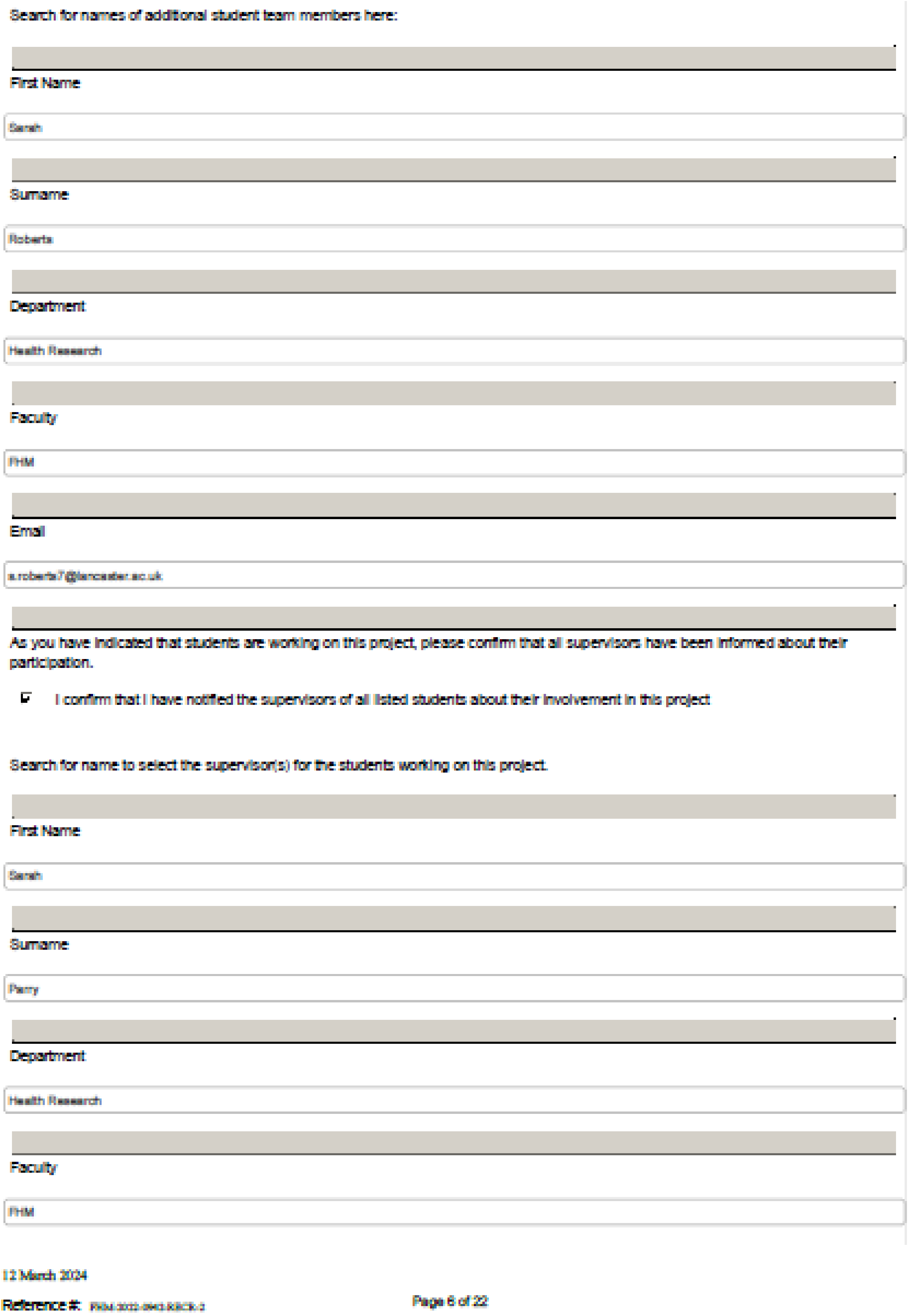

Search for names of additional student team members here:

First Name

Sarah

Surname

Roberts

Department

Health Research

Faculty

FHM

Email

s.roberts7@lancaster.ac.uk

As you have indicated that students are working on this project, please confirm that all supervisors have been informed about their participation.

☑ I confirm that I have notified the supervisors of all listed students about their involvement in this project

Search for name to select the supervisor(s) for the students working on this project.

First Name

Sarah

Surname

Parry

Department

Health Research

Faculty

FHM

12 March 2024

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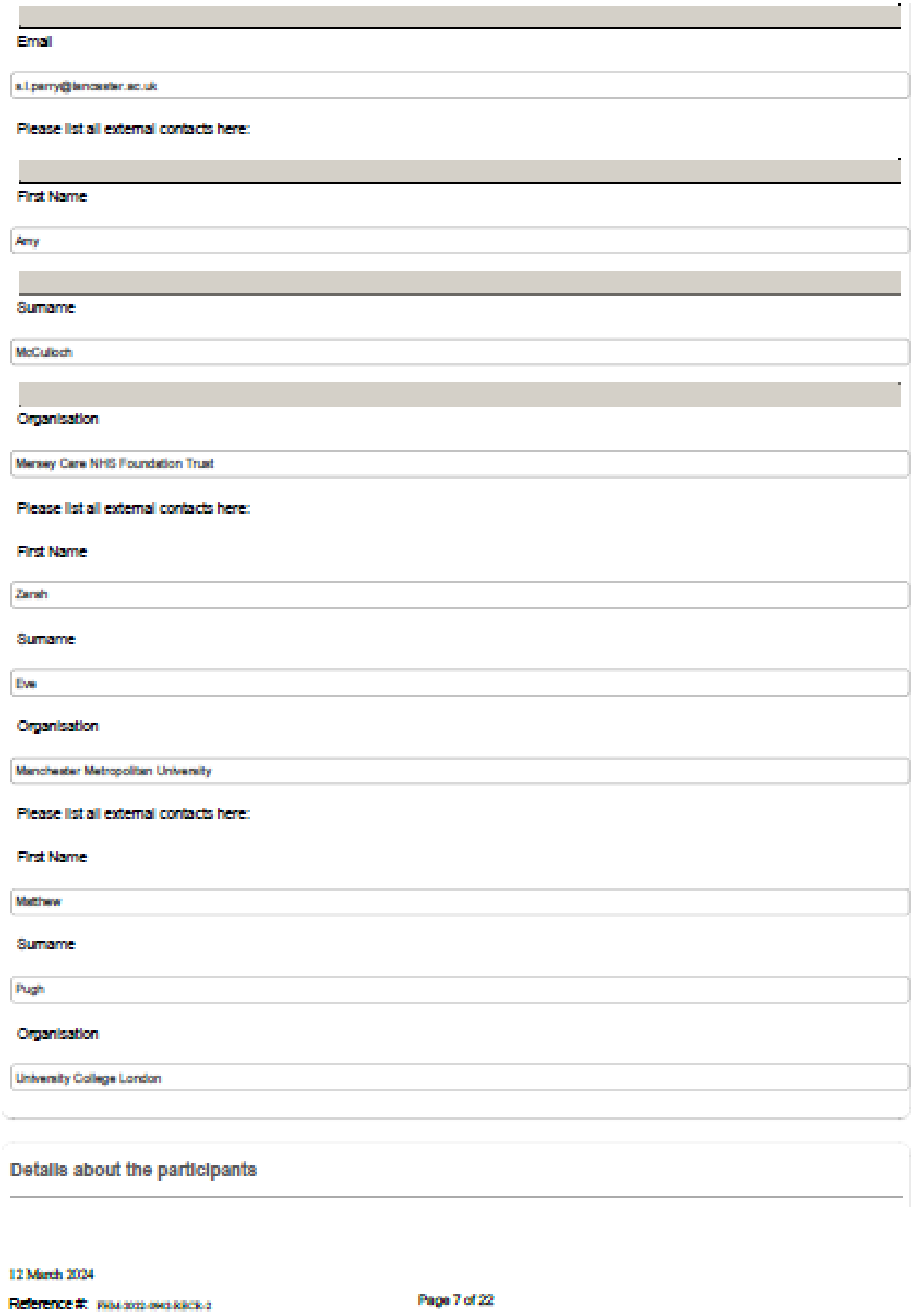

Email

s.l.parry@lancaster.ac.uk

Please list all external contacts here:

First Name

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McCulloch

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Mersey Care NHS Foundation Trust

Please list all external contacts here:

First Name

Zarah

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Eve

Organisation

Manchester Metropolitan University

Please list all external contacts here:

First Name

Matthew

Surname

Pugh

Organisation

University College London

Details about the participants

12 March 2024

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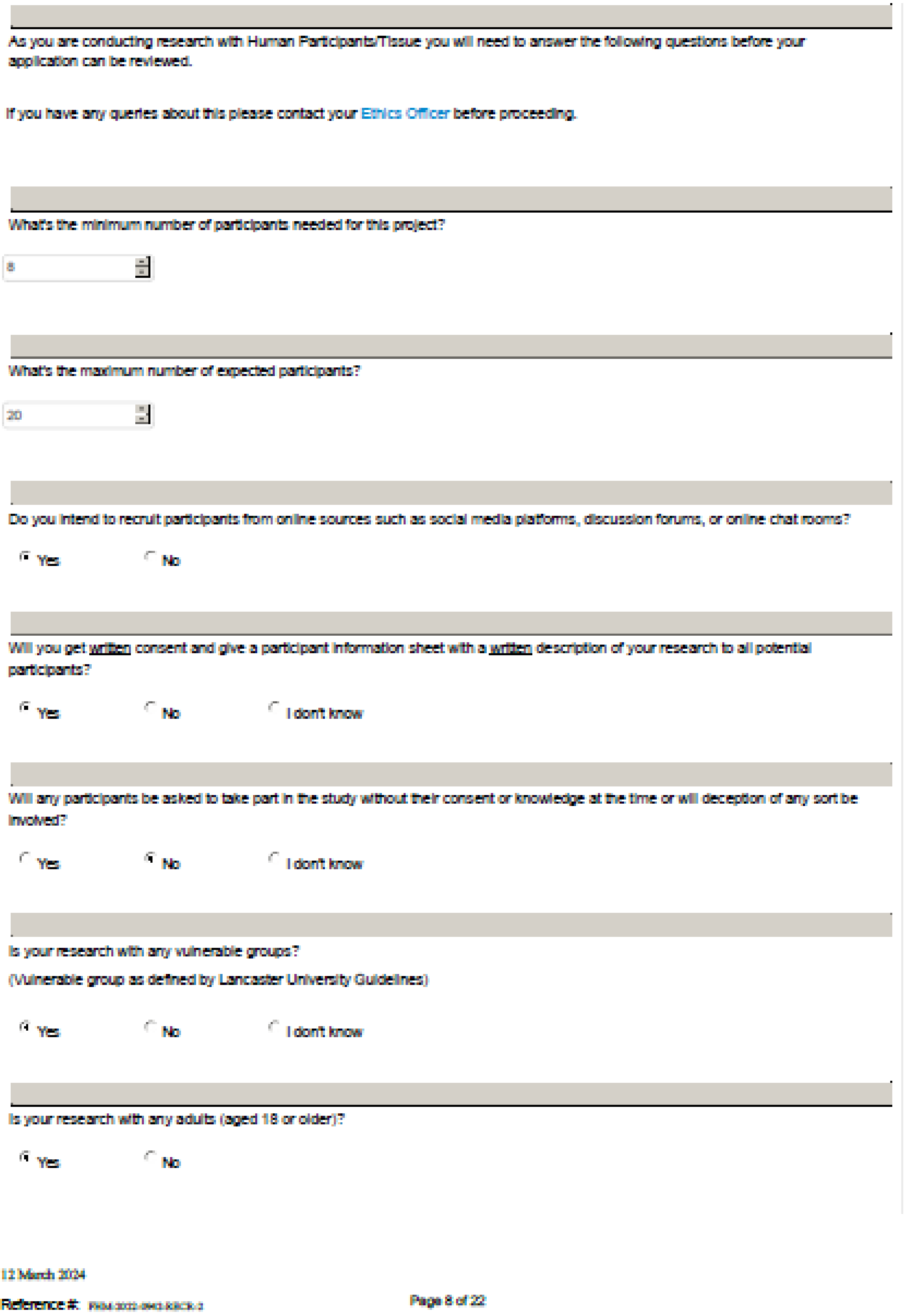

As you are conducting research with Human Participants/Tissue you will need to answer the following questions before your application can be reviewed.

If you have any queries about this please contact your Ethics Officer before proceeding.

What's the minimum number of participants needed for this project?

8

What's the maximum number of expected participants?

20

Do you intend to recruit participants from online sources such as social media platforms, discussion forums, or online chat rooms?

● Yes ○ No

Will you get written consent and give a participant information sheet with a written description of your research to all potential participants?

● Yes ○ No ○ I don't know

Will any participants be asked to take part in the study without their consent or knowledge at the time or will deception of any sort be involved?

○ Yes ● No ○ I don't know

Is your research with any vulnerable groups?

(Vulnerable group as defined by Lancaster University Guidelines)

● Yes ○ No ○ I don't know

Is your research with any adults (aged 18 or older)?

● Yes ○ No

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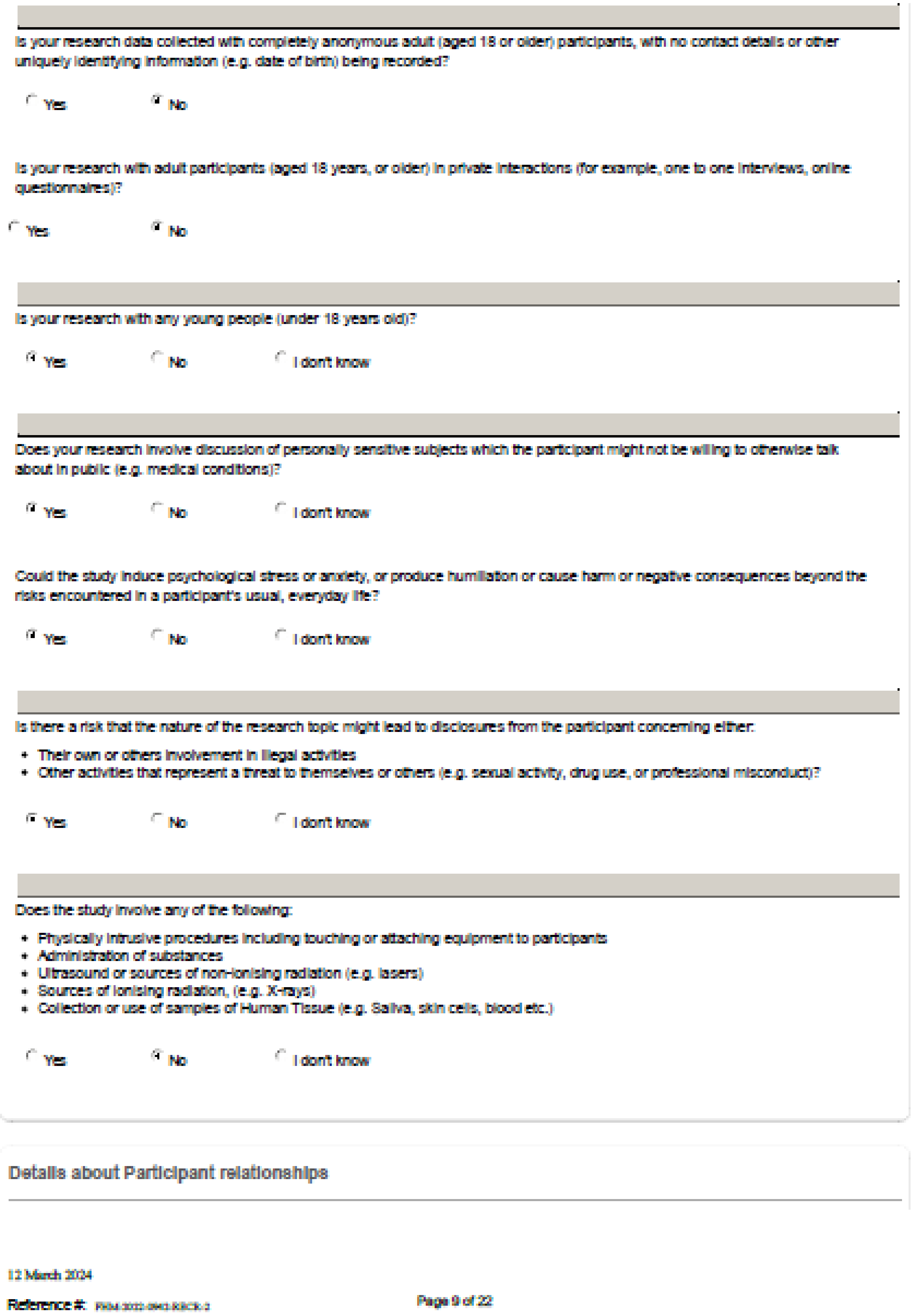

Is your research data collected with completely anonymous adult (aged 18 or older) participants, with no contact details or other uniquely identifying information (e.g. date of birth) being recorded?

○ Yes ● No

Is your research with adult participants (aged 18 years, or older) in private interactions (for example, one to one interviews, online questionnaires)?

○ Yes ● No

Is your research with any young people (under 18 years old)?

● Yes ○ No ○ I don't know

Does your research involve discussion of personally sensitive subjects which the participant might not be willing to otherwise talk about in public (e.g. medical conditions)?

● Yes ○ No ○ I don't know

Could the study induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life?

● Yes ○ No ○ I don't know

Is there a risk that the nature of the research topic might lead to disclosures from the participant concerning either:

- Their own or others involvement in illegal activities
- Other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?

● Yes ○ No ○ I don't know

Does the study involve any of the following:

- Physically intrusive procedures including touching or attaching equipment to participants
- Administration of substances
- Ultrasound or sources of non-ionising radiation (e.g. lasers)
- Sources of ionising radiation, (e.g. X-rays)
- Collection or use of samples of Human Tissue (e.g. Saliva, skin cells, blood etc.)

○ Yes ● No ○ I don't know

**Details about Participant relationships**

12 March 2024

Reference #: [illegible]

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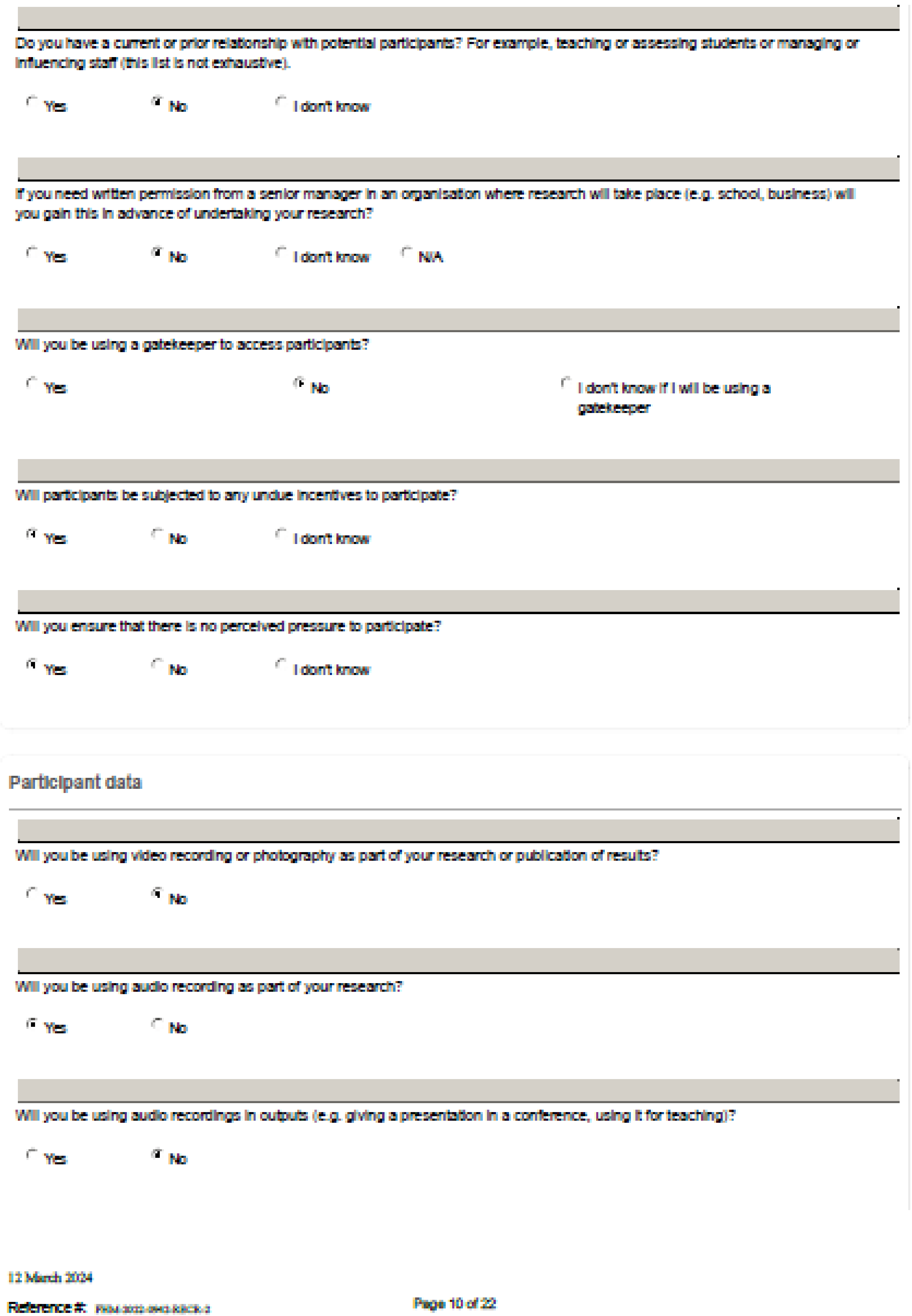

Do you have a current or prior relationship with potential participants? For example, teaching or assessing students or managing or influencing staff (this list is not exhaustive).

○ Yes ● No ○ I don't know

If you need written permission from a senior manager in an organisation where research will take place (e.g. school, business) will you gain this in advance of undertaking your research?

○ Yes ● No ○ I don't know ○ N/A

Will you be using a gatekeeper to access participants?

○ Yes ● No ○ I don't know if I will be using a gatekeeper

Will participants be subjected to any undue incentives to participate?

● Yes ○ No ○ I don't know

Will you ensure that there is no perceived pressure to participate?

● Yes ○ No ○ I don't know

## Participant data

Will you be using video recording or photography as part of your research or publication of results?

○ Yes ● No

Will you be using audio recording as part of your research?

● Yes ○ No

Will you be using audio recordings in outputs (e.g. giving a presentation in a conference, using it for teaching)?

○ Yes ● No

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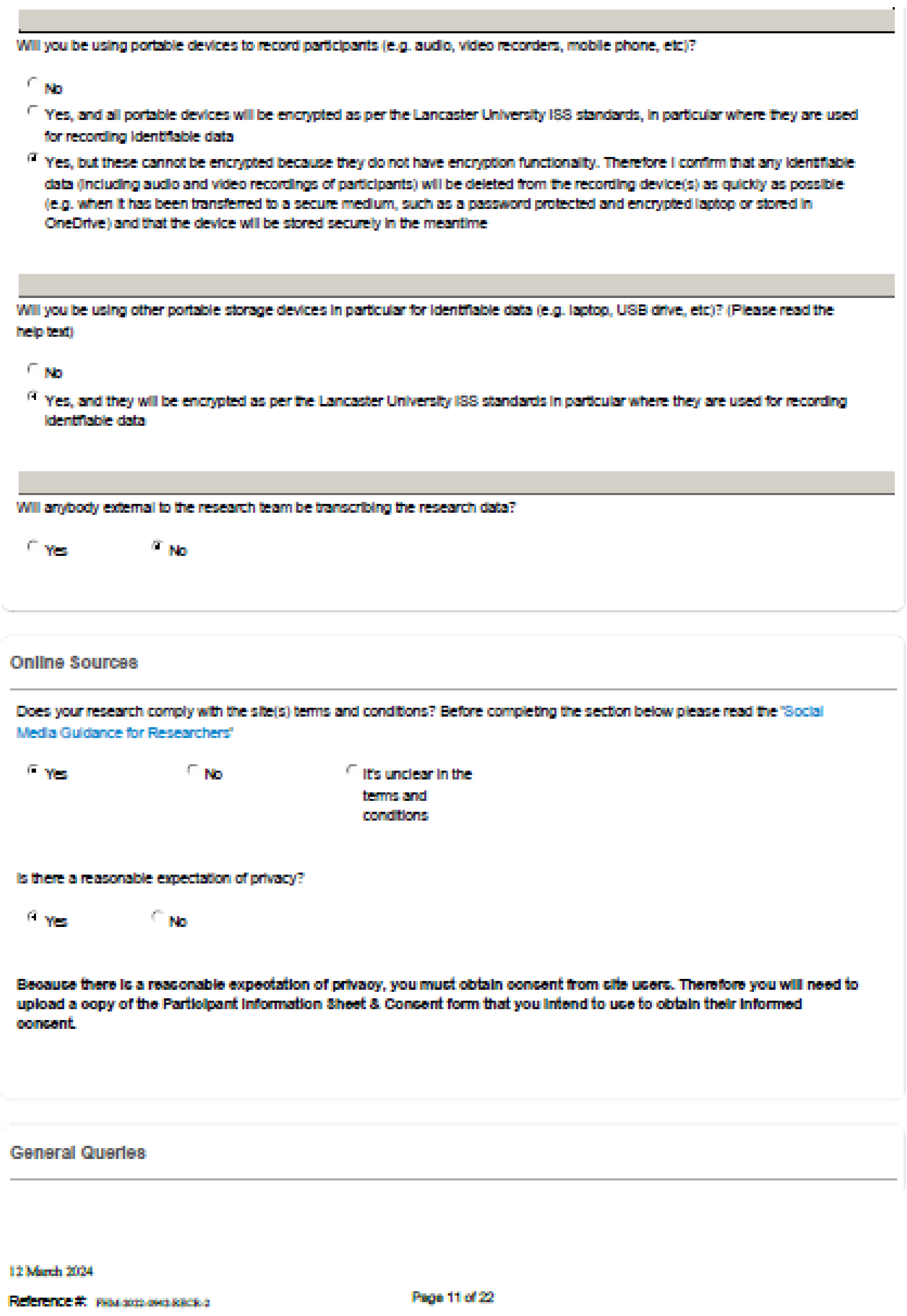
**Reference #:** [illegible] Page 10 of 22



Will you be using portable devices to record participants (e.g. audio, video recorders, mobile phone, etc)?

○ No

○ Yes, and all portable devices will be encrypted as per the Lancaster University ISS standards, in particular where they are used for recording identifiable data

● Yes, but these cannot be encrypted because they do not have encryption functionality. Therefore I confirm that any identifiable data (including audio and video recordings of participants) will be deleted from the recording device(s) as quickly as possible (e.g. when it has been transferred to a secure medium, such as a password protected and encrypted laptop or stored in OneDrive) and that the device will be stored securely in the meantime

Will you be using other portable storage devices in particular for identifiable data (e.g. laptop, USB drive, etc)? (Please read the help text)

○ No

● Yes, and they will be encrypted as per the Lancaster University ISS standards in particular where they are used for recording identifiable data

Will anybody external to the research team be transcribing the research data?

○ Yes ● No

## Online Sources

Does your research comply with the site(s) terms and conditions? Before completing the section below please read the 'Social Media Guidance for Researchers'

● Yes ○ No ○ It's unclear in the terms and conditions

Is there a reasonable expectation of privacy?

● Yes ○ No

**Because there is a reasonable expectation of privacy, you must obtain consent from site users. Therefore you will need to upload a copy of the Participant Information Sheet & Consent form that you intend to use to obtain their informed consent.**

## General Queries

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Reference #: [illegible]

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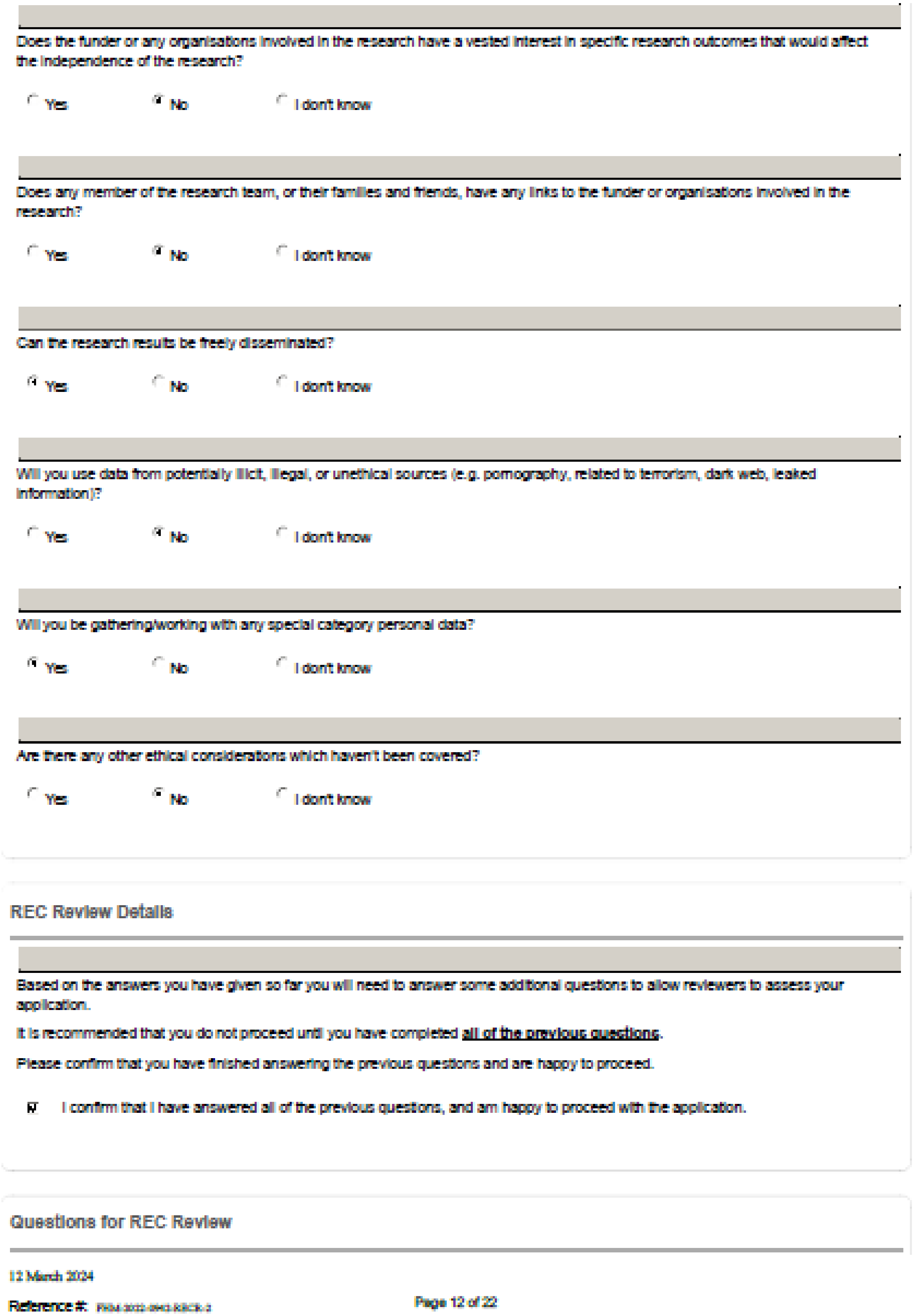

Does the funder or any organisations involved in the research have a vested interest in specific research outcomes that would affect the independence of the research?

○ Yes ● No ○ I don't know

Does any member of the research team, or their families and friends, have any links to the funder or organisations involved in the research?

○ Yes ● No ○ I don't know

Can the research results be freely disseminated?

● Yes ○ No ○ I don't know

Will you use data from potentially illicit, illegal, or unethical sources (e.g. pornography, related to terrorism, dark web, leaked information)?

○ Yes ● No ○ I don't know

Will you be gathering/working with any special category personal data?

● Yes ○ No ○ I don't know

Are there any other ethical considerations which haven't been covered?

○ Yes ● No ○ I don't know

**REC Review Details**

Based on the answers you have given so far you will need to answer some additional questions to allow reviewers to assess your application.

It is recommended that you do not proceed until you have completed **all of the previous questions**.

Please confirm that you have finished answering the previous questions and are happy to proceed.

☑ I confirm that I have answered all of the previous questions, and am happy to proceed with the application.

**Questions for REC Review**

12 March 2024

**Reference #:** [illegible]

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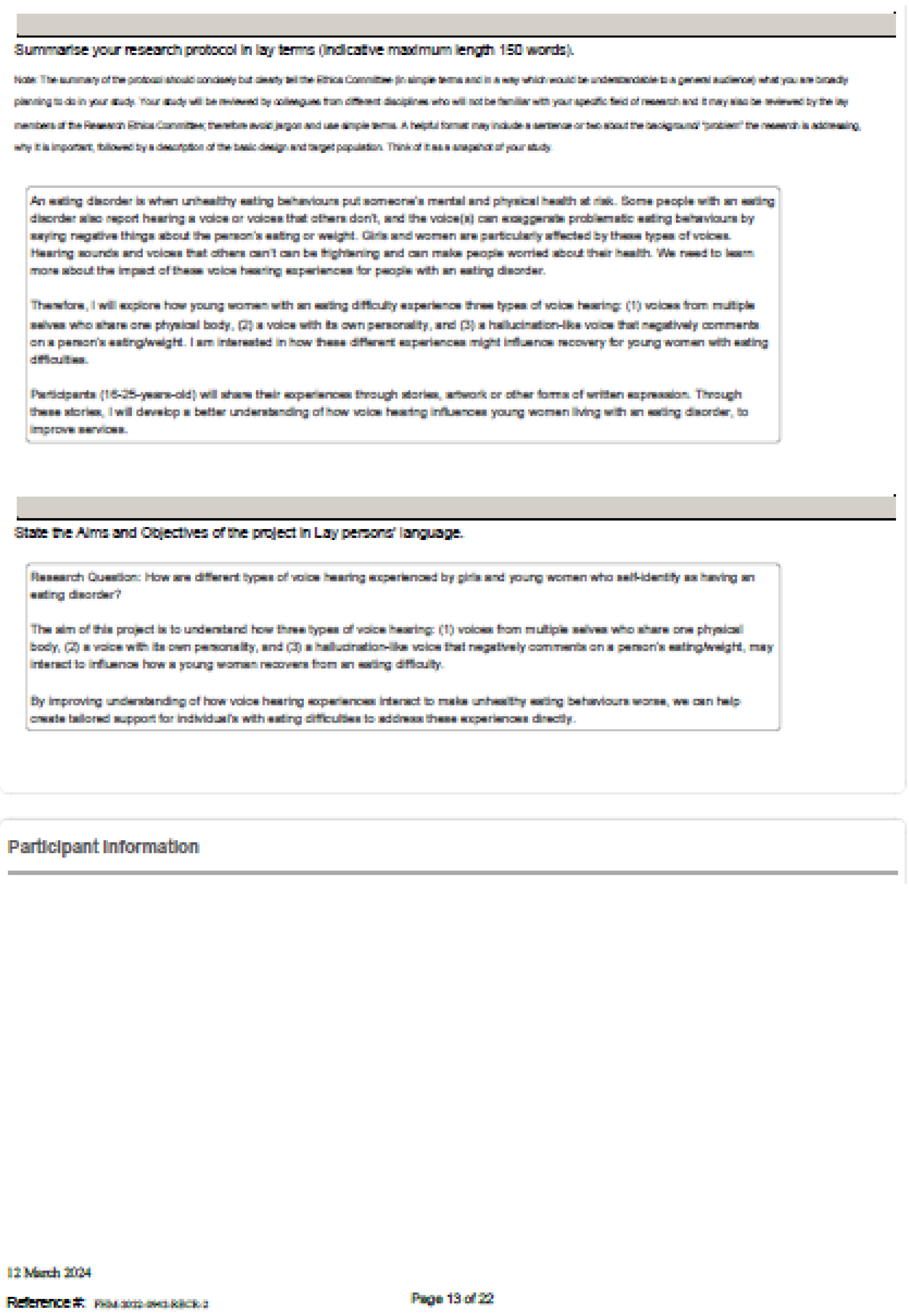

Summarise your research protocol in lay terms (indicative maximum length 150 words).

Note: The summary of the protocol should concisely but clearly tell the Ethics Committee (in simple terms and in a way which would be understandable to a general audience) what you are broadly planning to do in your study. Your study will be reviewed by colleagues from different disciplines who will not be familiar with your specific field of research and it may also be reviewed by the lay members of the Research Ethics Committee; therefore avoid jargon and use simple terms. A helpful format may include a sentence or two about the background/ "problem" the research is addressing, why it is important, followed by a description of the basic design and target population. Think of it as a snapshot of your study.

An eating disorder is when unhealthy eating behaviours put someone's mental and physical health at risk. Some people with an eating disorder also report hearing a voice or voices that others don't, and the voice(s) can exaggerate problematic eating behaviours by saying negative things about the person's eating or weight. Girls and women are particularly affected by these types of voices. Hearing sounds and voices that others can't can be frightening and can make people worried about their health. We need to learn more about the impact of these voice hearing experiences for people with an eating disorder.

Therefore, I will explore how young women with an eating difficulty experience three types of voice hearing: (1) voices from multiple selves who share one physical body, (2) a voice with its own personality, and (3) a hallucination-like voice that negatively comments on a person's eating/weight. I am interested in how these different experiences might influence recovery for young women with eating difficulties.

Participants (16-25-years-old) will share their experiences through stories, artwork or other forms of written expression. Through these stories, I will develop a better understanding of how voice hearing influences young women living with an eating disorder, to improve services.

State the Aims and Objectives of the project in Lay persons' language.

Research Question: How are different types of voice hearing experienced by girls and young women who self-identify as having an eating disorder?

The aim of this project is to understand how three types of voice hearing: (1) voices from multiple selves who share one physical body, (2) a voice with its own personality, and (3) a hallucination-like voice that negatively comments on a person's eating/weight, may interact to influence how a young woman recovers from an eating difficulty.

By improving understanding of how voice hearing experiences interact to make unhealthy eating behaviours worse, we can help create tailored support for individuals with eating difficulties to address these experiences directly.

## Participant Information

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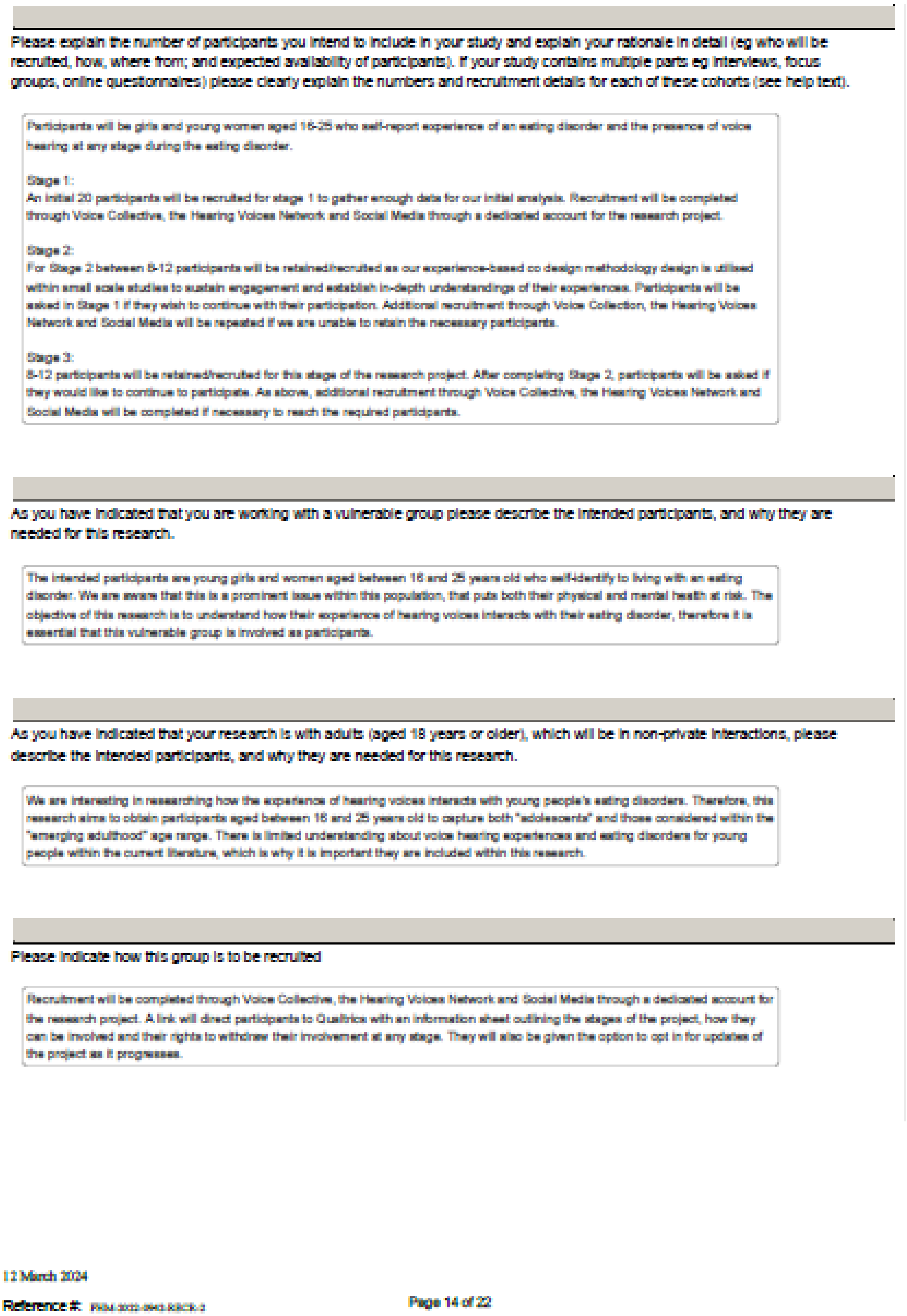
**Reference #:** [illegible] Page 13 of 22



Please explain the number of participants you intend to include in your study and explain your rationale in detail (eg who will be recruited, how, where from; and expected availability of participants). If your study contains multiple parts eg interviews, focus groups, online questionnaires) please clearly explain the numbers and recruitment details for each of these cohorts (see help text).

Participants will be girls and young women aged 16-25 who self-report experience of an eating disorder and the presence of voice hearing at any stage during the eating disorder.

Stage 1:
An initial 20 participants will be recruited for stage 1 to gather enough data for our initial analysis. Recruitment will be completed through Voice Collective, the Hearing Voices Network and Social Media through a dedicated account for the research project.

Stage 2:
For Stage 2 between 8-12 participants will be retained/recruited as our experience-based co design methodology design is utilised within small scale studies to sustain engagement and establish in-depth understandings of their experiences. Participants will be asked in Stage 1 if they wish to continue with their participation. Additional recruitment through Voice Collection, the Hearing Voices Network and Social Media will be repeated if we are unable to retain the necessary participants.

Stage 3:
8-12 participants will be retained/recruited for this stage of the research project. After completing Stage 2, participants will be asked if they would like to continue to participate. As above, additional recruitment through Voice Collective, the Hearing Voices Network and Social Media will be completed if necessary to reach the required participants.

As you have indicated that you are working with a vulnerable group please describe the intended participants, and why they are needed for this research.

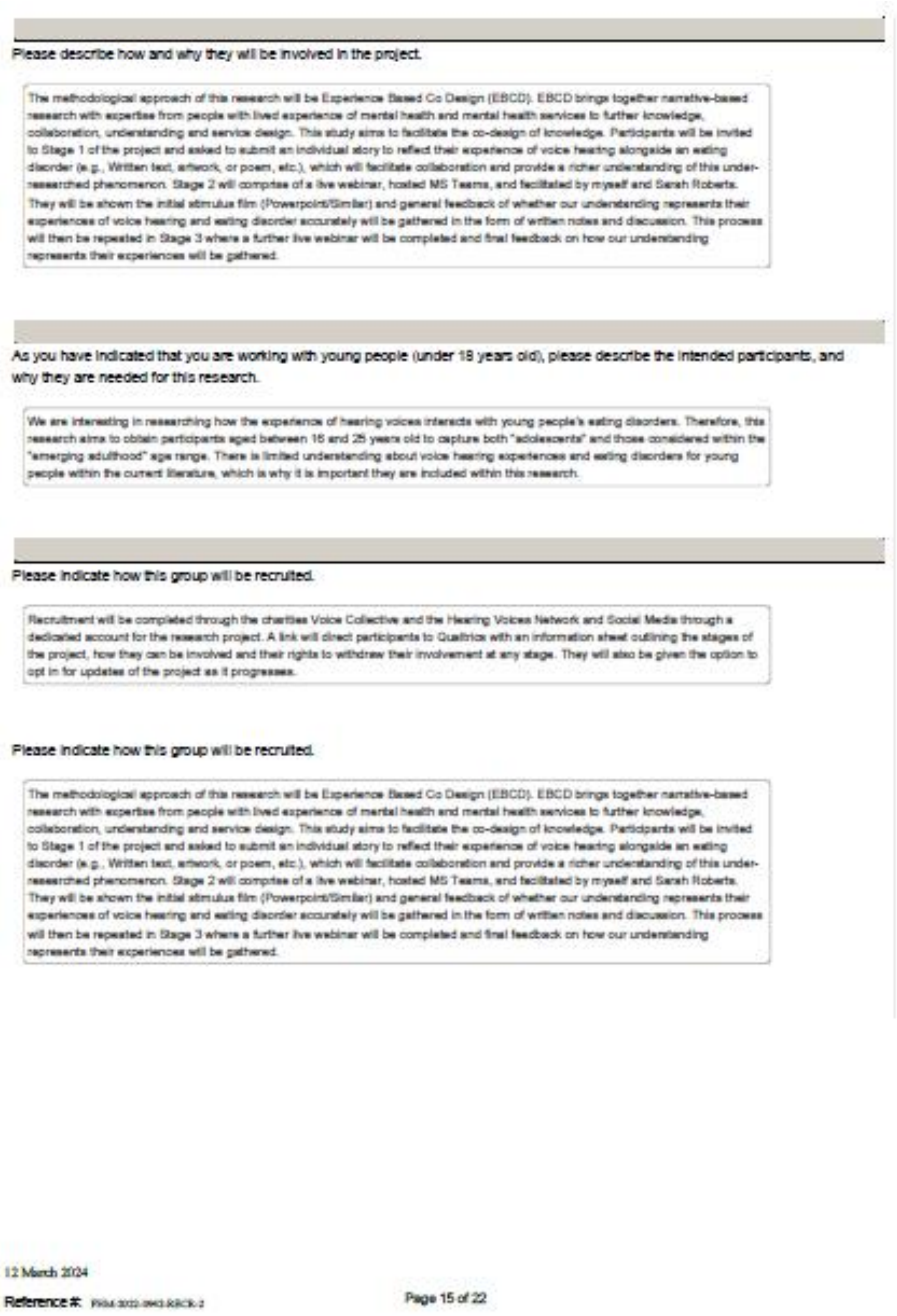
The intended participants are young girls and women aged between 16 and 25 years old who self-identify to living with an eating disorder. We are aware that this is a prominent issue within this population, that puts both their physical and mental health at risk. The objective of this research is to understand how their experience of hearing voices interacts with their eating disorder, therefore it is essential that this vulnerable group is involved as participants.

As you have indicated that your research is with adults (aged 18 years or older), which will be in non-private interactions, please describe the intended participants, and why they are needed for this research.

We are interesting in researching how the experience of hearing voices interacts with young people's eating disorders. Therefore, this research aims to obtain participants aged between 16 and 25 years old to capture both "adolescents" and those considered within the "emerging adulthood" age range. There is limited understanding about voice hearing experiences and eating disorders for young people within the current literature, which is why it is important they are included within this research.

Please indicate how this group is to be recruited

Recruitment will be completed through Voice Collective, the Hearing Voices Network and Social Media through a dedicated account for the research project. A link will direct participants to Qualtrics with an information sheet outlining the stages of the project, how they can be involved and their rights to withdraw their involvement at any stage. They will also be given the option to opt in for updates of the project as it progresses.



Please describe how and why they will be involved in the project.

The methodological approach of this research will be Experience Based Co Design (EBCD). EBCD brings together narrative-based research with expertise from people with lived experience of mental health and mental health services to further knowledge, collaboration, understanding and service design. This study aims to facilitate the co-design of knowledge. Participants will be invited to Stage 1 of the project and asked to submit an individual story to reflect their experience of voice hearing alongside an eating disorder (e.g., Written text, artwork, or poem, etc.), which will facilitate collaboration and provide a richer understanding of this under-researched phenomenon. Stage 2 will comprise of a live webinar, hosted MS Teams, and facilitated by myself and Sarah Roberts. They will be shown the initial stimulus film (Powerpoint/Similar) and general feedback of whether our understanding represents their experiences of voice hearing and eating disorder accurately will be gathered in the form of written notes and discussion. This process will then be repeated in Stage 3 where a further live webinar will be completed and final feedback on how our understanding represents their experiences will be gathered.

As you have indicated that you are working with young people (under 18 years old), please describe the intended participants, and why they are needed for this research.

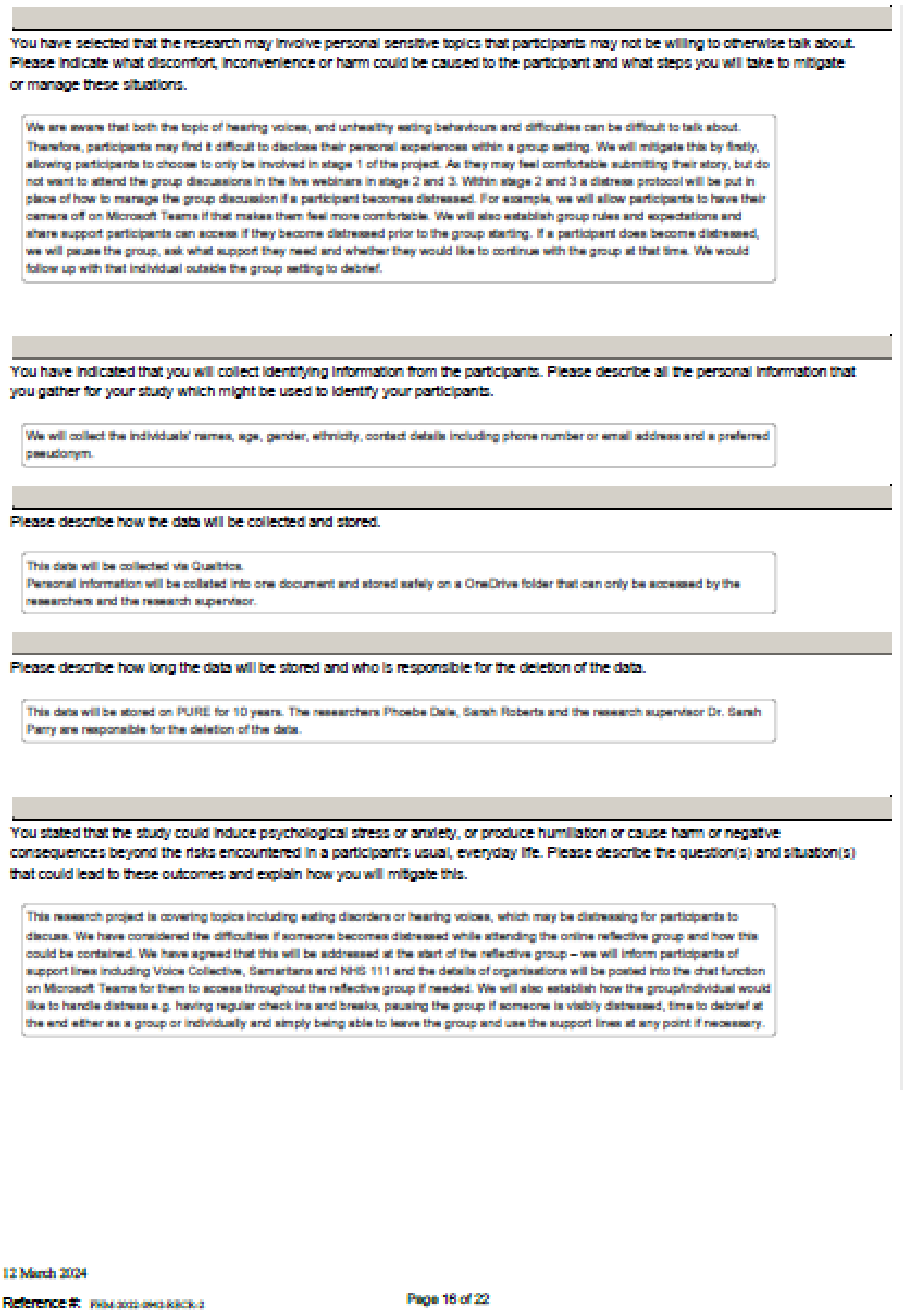
We are interesting in researching how the experience of hearing voices interacts with young people's eating disorders. Therefore, this research aims to obtain participants aged between 16 and 25 years old to capture both "adolescents" and those considered within the "emerging adulthood" age range. There is limited understanding about voice hearing experiences and eating disorders for young people within the current literature, which is why it is important they are included within this research.

Please indicate how this group will be recruited.

Recruitment will be completed through the charities Voice Collective and the Hearing Voices Network and Social Media through a dedicated account for the research project. A link will direct participants to Qualtrics with an information sheet outlining the stages of the project, how they can be involved and their rights to withdraw their involvement at any stage. They will also be given the option to opt in for updates of the project as it progresses.

Please indicate how this group will be recruited.

The methodological approach of this research will be Experience Based Co Design (EBCD). EBCD brings together narrative-based research with expertise from people with lived experience of mental health and mental health services to further knowledge, collaboration, understanding and service design. This study aims to facilitate the co-design of knowledge. Participants will be invited to Stage 1 of the project and asked to submit an individual story to reflect their experience of voice hearing alongside an eating disorder (e.g., Written text, artwork, or poem, etc.), which will facilitate collaboration and provide a richer understanding of this under-researched phenomenon. Stage 2 will comprise of a live webinar, hosted MS Teams, and facilitated by myself and Sarah Roberts. They will be shown the initial stimulus film (Powerpoint/Similar) and general feedback of whether our understanding represents their experiences of voice hearing and eating disorder accurately will be gathered in the form of written notes and discussion. This process will then be repeated in Stage 3 where a further live webinar will be completed and final feedback on how our understanding represents their experiences will be gathered.



You have selected that the research may involve personal sensitive topics that participants may not be willing to otherwise talk about. Please indicate what discomfort, inconvenience or harm could be caused to the participant and what steps you will take to mitigate or manage these situations.

We are aware that both the topic of hearing voices, and unhealthy eating behaviours and difficulties can be difficult to talk about. Therefore, participants may find it difficult to disclose their personal experiences within a group setting. We will mitigate this by firstly, allowing participants to choose to only be involved in stage 1 of the project. As they may feel comfortable submitting their story, but do not want to attend the group discussions in the live webinars in stage 2 and 3. Within stage 2 and 3 a distress protocol will be put in place of how to manage the group discussion if a participant becomes distressed. For example, we will allow participants to have their camera off on Microsoft Teams if that makes them feel more comfortable. We will also establish group rules and expectations and share support participants can access if they become distressed prior to the group starting. If a participant does become distressed, we will pause the group, ask what support they need and whether they would like to continue with the group at that time. We would follow up with that individual outside the group setting to debrief.

You have indicated that you will collect identifying information from the participants. Please describe all the personal information that you gather for your study which might be used to identify your participants.

We will collect the individuals' names, age, gender, ethnicity, contact details including phone number or email address and a preferred pseudonym.

Please describe how the data will be collected and stored.

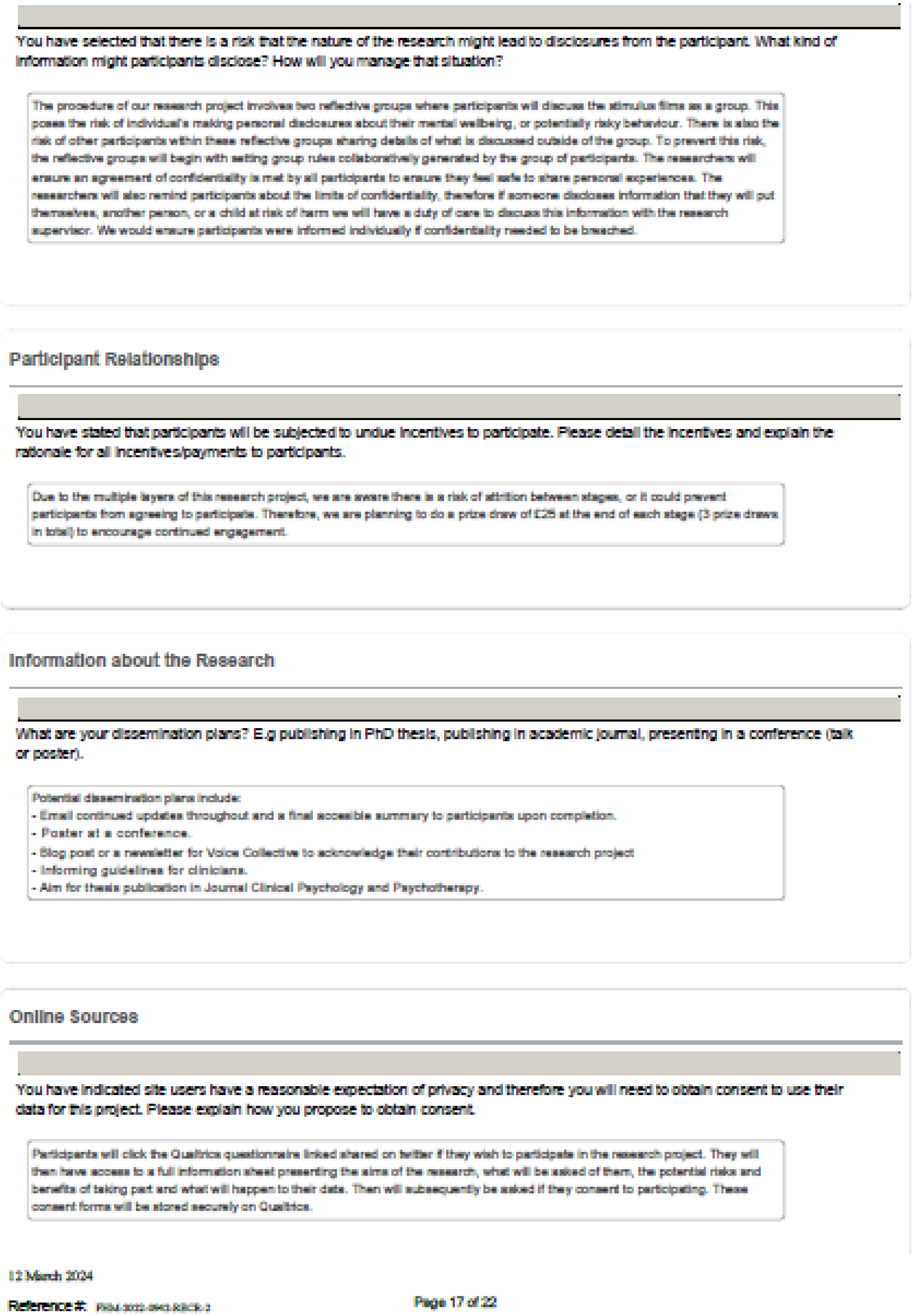
This data will be collected via Qualtrics.
Personal information will be collated into one document and stored safely on a OneDrive folder that can only be accessed by the researchers and the research supervisor.

Please describe how long the data will be stored and who is responsible for the deletion of the data.

This data will be stored on PURE for 10 years. The researchers Phoebe Dale, Sarah Roberts and the research supervisor Dr. Sarah Parry are responsible for the deletion of the data.

You stated that the study could induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life. Please describe the question(s) and situation(s) that could lead to these outcomes and explain how you will mitigate this.

This research project is covering topics including eating disorders or hearing voices, which may be distressing for participants to discuss. We have considered the difficulties if someone becomes distressed while attending the online reflective group and how this could be contained. We have agreed that this will be addressed at the start of the reflective group – we will inform participants of support lines including Voice Collective, Samaritans and NHS 111 and the details of organisations will be posted into the chat function on Microsoft Teams for them to access throughout the reflective group if needed. We will also establish how the group/individual would like to handle distress e.g. having regular check ins and breaks, pausing the group if someone is visibly distressed, time to debrief at the end either as a group or individually and simply being able to leave the group and use the support lines at any point if necessary.



You have selected that there is a risk that the nature of the research might lead to disclosures from the participant. What kind of information might participants disclose? How will you manage that situation?

The procedure of our research project involves two reflective groups where participants will discuss the stimulus films as a group. This poses the risk of individual's making personal disclosures about their mental wellbeing, or potentially risky behaviour. There is also the risk of other participants within these reflective groups sharing details of what is discussed outside of the group. To prevent this risk, the reflective groups will begin with setting group rules collaboratively generated by the group of participants. The researchers will ensure an agreement of confidentiality is met by all participants to ensure they feel safe to share personal experiences. The researchers will also remind participants about the limits of confidentiality, therefore if someone discloses information that they will put themselves, another person, or a child at risk of harm we will have a duty of care to discuss this information with the research supervisor. We would ensure participants were informed individually if confidentiality needed to be breached.

## Participant Relationships

You have stated that participants will be subjected to undue incentives to participate. Please detail the incentives and explain the rationale for all incentives/payments to participants.

Due to the multiple layers of this research project, we are aware there is a risk of attrition between stages, or it could prevent participants from agreeing to participate. Therefore, we are planning to do a prize draw of £25 at the end of each stage (3 prize draws in total) to encourage continued engagement.

## Information about the Research

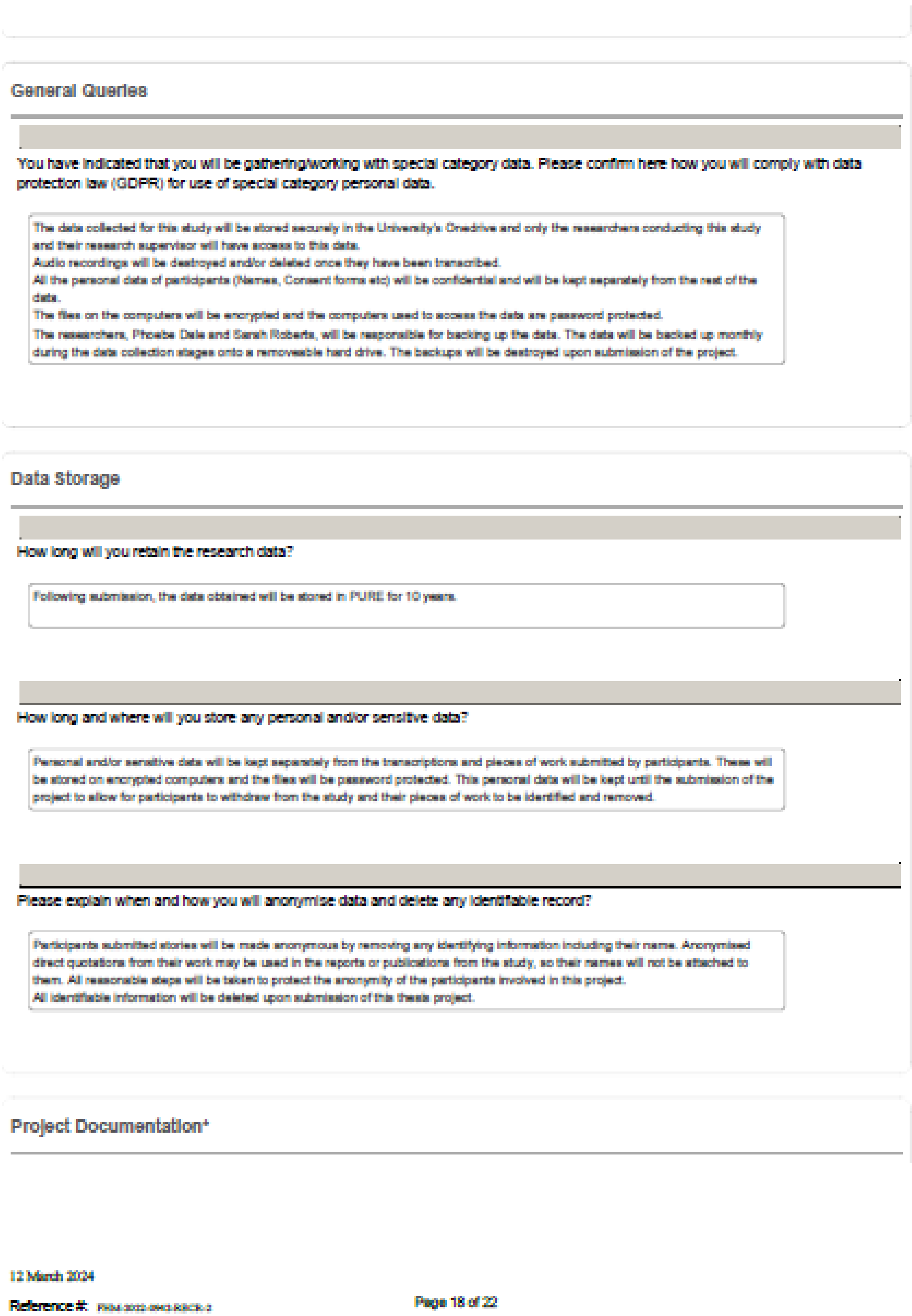
What are your dissemination plans? E.g publishing in PhD thesis, publishing in academic journal, presenting in a conference (talk or poster).

Potential dissemination plans include:
- Email continued updates throughout and a final accessible summary to participants upon completion.
- Poster at a conference.
- Blog post or a newsletter for Voice Collective to acknowledge their contributions to the research project
- Informing guidelines for clinicians.
- Aim for thesis publication in Journal Clinical Psychology and Psychotherapy.

## Online Sources

You have indicated site users have a reasonable expectation of privacy and therefore you will need to obtain consent to use their data for this project. Please explain how you propose to obtain consent.

Participants will click the Qualtrics questionnaire linked shared on twitter if they wish to participate in the research project. They will then have access to a full information sheet presenting the aims of the research, what will be asked of them, the potential risks and benefits of taking part and what will happen to their data. Then will subsequently be asked if they consent to participating. These consent forms will be stored securely on Qualtrics.



## General Queries

You have indicated that you will be gathering/working with special category data. Please confirm here how you will comply with data protection law (GDPR) for use of special category personal data.

The data collected for this study will be stored securely in the University's Onedrive and only the researchers conducting this study and their research supervisor will have access to this data.
Audio recordings will be destroyed and/or deleted once they have been transcribed.
All the personal data of participants (Names, Consent forms etc) will be confidential and will be kept separately from the rest of the data.
The files on the computers will be encrypted and the computers used to access the data are password protected.
The researchers, Phoebe Dale and Sarah Roberts, will be responsible for backing up the data. The data will be backed up monthly during the data collection stages onto a removeable hard drive. The backups will be destroyed upon submission of the project.

## Data Storage

How long will you retain the research data?

Following submission, the data obtained will be stored in PURE for 10 years.

How long and where will you store any personal and/or sensitive data?

Personal and/or sensitive data will be kept separately from the transcriptions and pieces of work submitted by participants. These will be stored on encrypted computers and the files will be password protected. This personal data will be kept until the submission of the project to allow for participants to withdraw from the study and their pieces of work to be identified and removed.

Please explain when and how you will anonymise data and delete any identifiable record?

Participants submitted stories will be made anonymous by removing any identifying information including their name. Anonymised direct quotations from their work may be used in the reports or publications from the study, so their names will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
All identifiable information will be deleted upon submission of this thesis project.

## Project Documentation*

12 March 2024

**Reference #:** [illegible]

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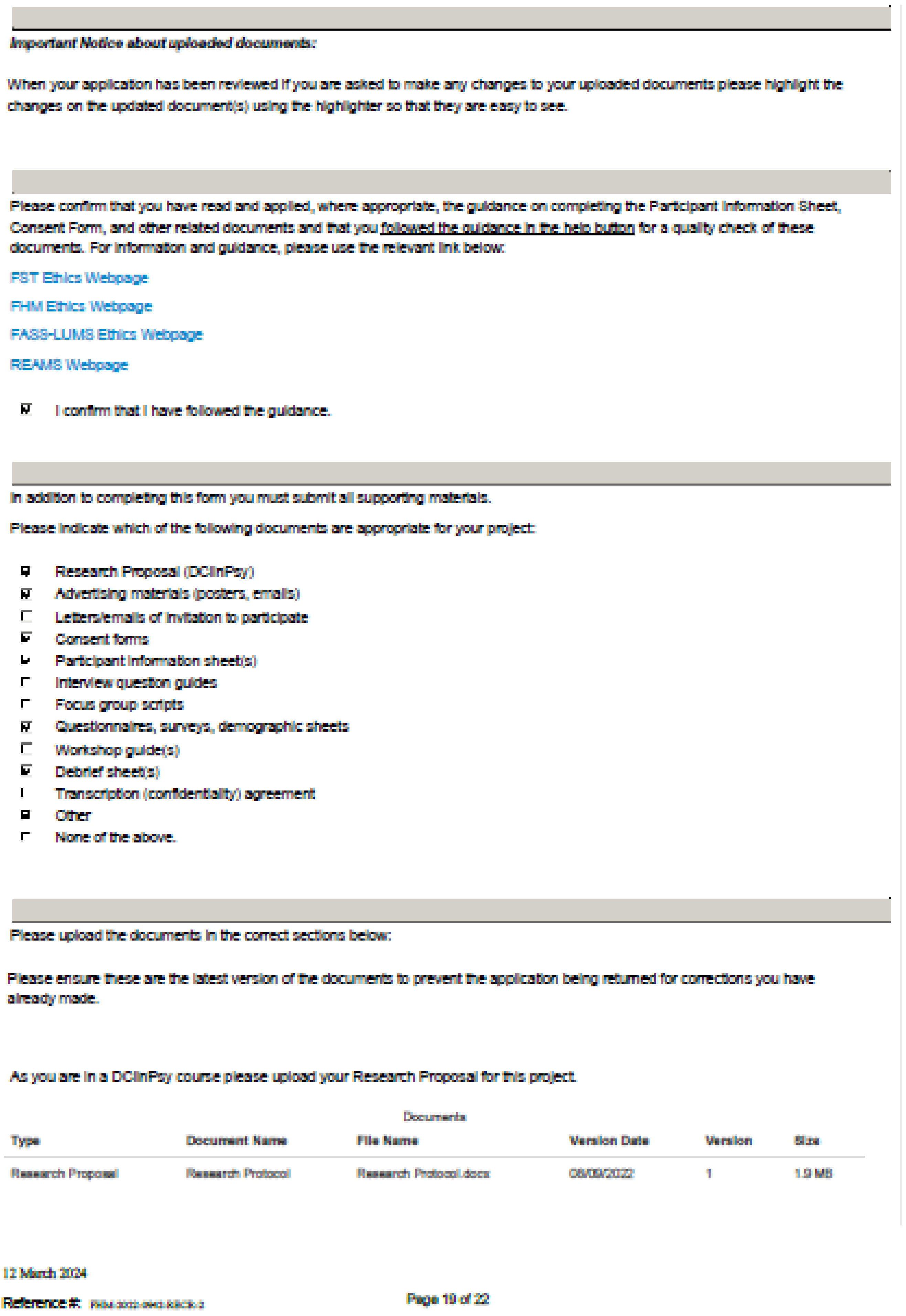


***Important Notice about uploaded documents:***

When your application has been reviewed if you are asked to make any changes to your uploaded documents please highlight the changes on the updated document(s) using the highlighter so that they are easy to see.

Please confirm that you have read and applied, where appropriate, the guidance on completing the Participant Information Sheet, Consent Form, and other related documents and that you followed the guidance in the help button for a quality check of these documents. For information and guidance, please use the relevant link below:

FST Ethics Webpage

FHM Ethics Webpage

FASS-LUMS Ethics Webpage

REAMS Webpage

☑ I confirm that I have followed the guidance.

In addition to completing this form you must submit all supporting materials.

Please indicate which of the following documents are appropriate for your project:

- ☑ Research Proposal (DClinPsy)
- ☑ Advertising materials (posters, emails)
- ☐ Letters/emails of invitation to participate
- ☑ Consent forms
- ☑ Participant information sheet(s)
- ☐ Interview question guides
- ☐ Focus group scripts
- ☑ Questionnaires, surveys, demographic sheets
- ☐ Workshop guide(s)
- ☑ Debrief sheet(s)
- ☐ Transcription (confidentiality) agreement
- ☑ Other
- ☐ None of the above.

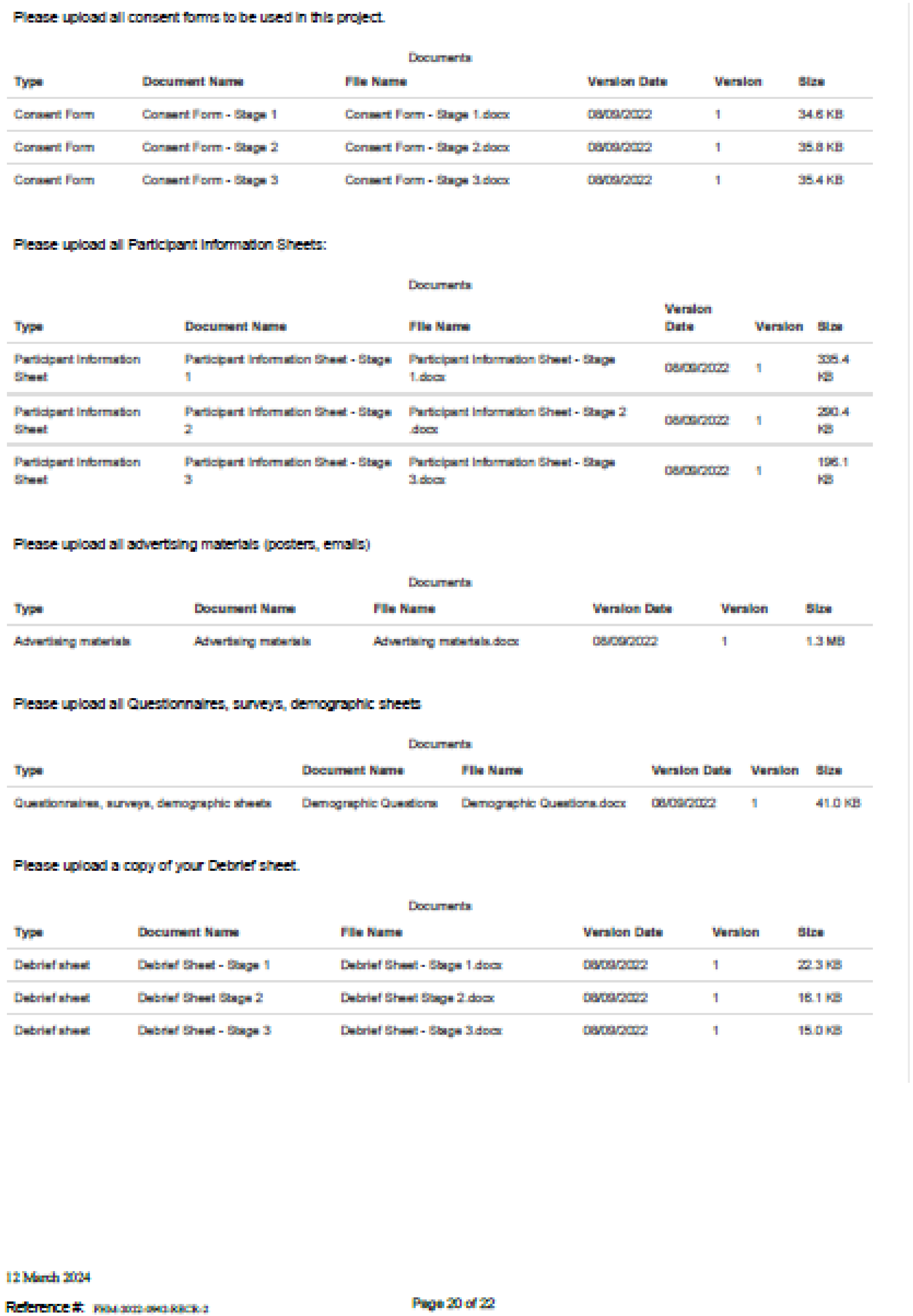
Please upload the documents in the correct sections below:

Please ensure these are the latest version of the documents to prevent the application being returned for corrections you have already made.

As you are in a DClinPsy course please upload your Research Proposal for this project.

Documents

| Type | Document Name | File Name | Version Date | Version | Size |
|---|---|---|---|---|---|
| Research Proposal | Research Protocol | Research Protocol.docx | 08/09/2022 | 1 | 1.9 MB |



Please upload all consent forms to be used in this project.

Documents

| Type | Document Name | File Name | Version Date | Version | Size |
|---|---|---|---|---|---|
| Consent Form | Consent Form - Stage 1 | Consent Form - Stage 1.docx | 08/09/2022 | 1 | 34.6 KB |
| Consent Form | Consent Form - Stage 2 | Consent Form - Stage 2.docx | 08/09/2022 | 1 | 35.8 KB |
| Consent Form | Consent Form - Stage 3 | Consent Form - Stage 3.docx | 08/09/2022 | 1 | 35.4 KB |

Please upload all Participant Information Sheets:

Documents

| Type | Document Name | File Name | Version Date | Version | Size |
|---|---|---|---|---|---|
| Participant Information Sheet | Participant Information Sheet - Stage 1 | Participant Information Sheet - Stage 1.docx | 08/09/2022 | 1 | 335.4 KB |
| Participant Information Sheet | Participant Information Sheet - Stage 2 | Participant Information Sheet - Stage 2 .docx | 08/09/2022 | 1 | 290.4 KB |
| Participant Information Sheet | Participant Information Sheet - Stage 3 | Participant Information Sheet - Stage 3.docx | 08/09/2022 | 1 | 196.1 KB |

Please upload all advertising materials (posters, emails)

Documents

| Type | Document Name | File Name | Version Date | Version | Size |
|---|---|---|---|---|---|
| Advertising materials | Advertising materials | Advertising materials.docx | 08/09/2022 | 1 | 1.3 MB |

Please upload all Questionnaires, surveys, demographic sheets

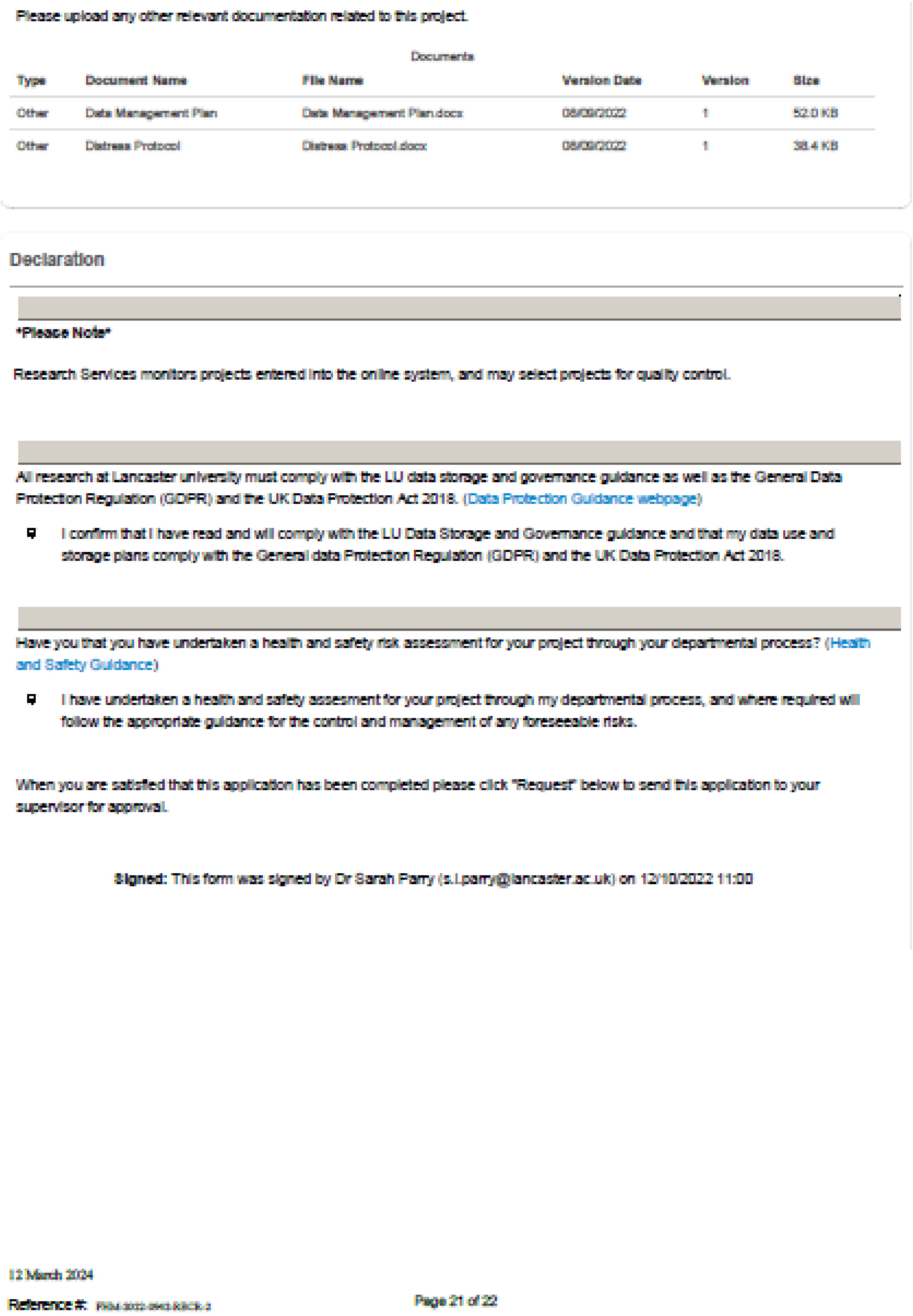
Documents

| Type | Document Name | File Name | Version Date | Version | Size |
|---|---|---|---|---|---|
| Questionnaires, surveys, demographic sheets | Demographic Questions | Demographic Questions.docx | 08/09/2022 | 1 | 41.0 KB |

Please upload a copy of your Debrief sheet.

Documents

| Type | Document Name | File Name | Version Date | Version | Size |
|---|---|---|---|---|---|
| Debrief sheet | Debrief Sheet - Stage 1 | Debrief Sheet - Stage 1.docx | 08/09/2022 | 1 | 22.3 KB |
| Debrief sheet | Debrief Sheet Stage 2 | Debrief Sheet Stage 2.docx | 08/09/2022 | 1 | 16.1 KB |
| Debrief sheet | Debrief Sheet - Stage 3 | Debrief Sheet - Stage 3.docx | 08/09/2022 | 1 | 15.0 KB |



Please upload any other relevant documentation related to this project.

Documents

| Type | Document Name | File Name | Version Date | Version | Size |
|---|---|---|---|---|---|
| Other | Data Management Plan | Data Management Plan.docx | 08/09/2022 | 1 | 52.0 KB |
| Other | Distress Protocol | Distress Protocol.docx | 08/09/2022 | 1 | 38.4 KB |

## Declaration

***Please Note***

Research Services monitors projects entered into the online system, and may select projects for quality control.

All research at Lancaster university must comply with the LU data storage and governance guidance as well as the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. (Data Protection Guidance webpage)

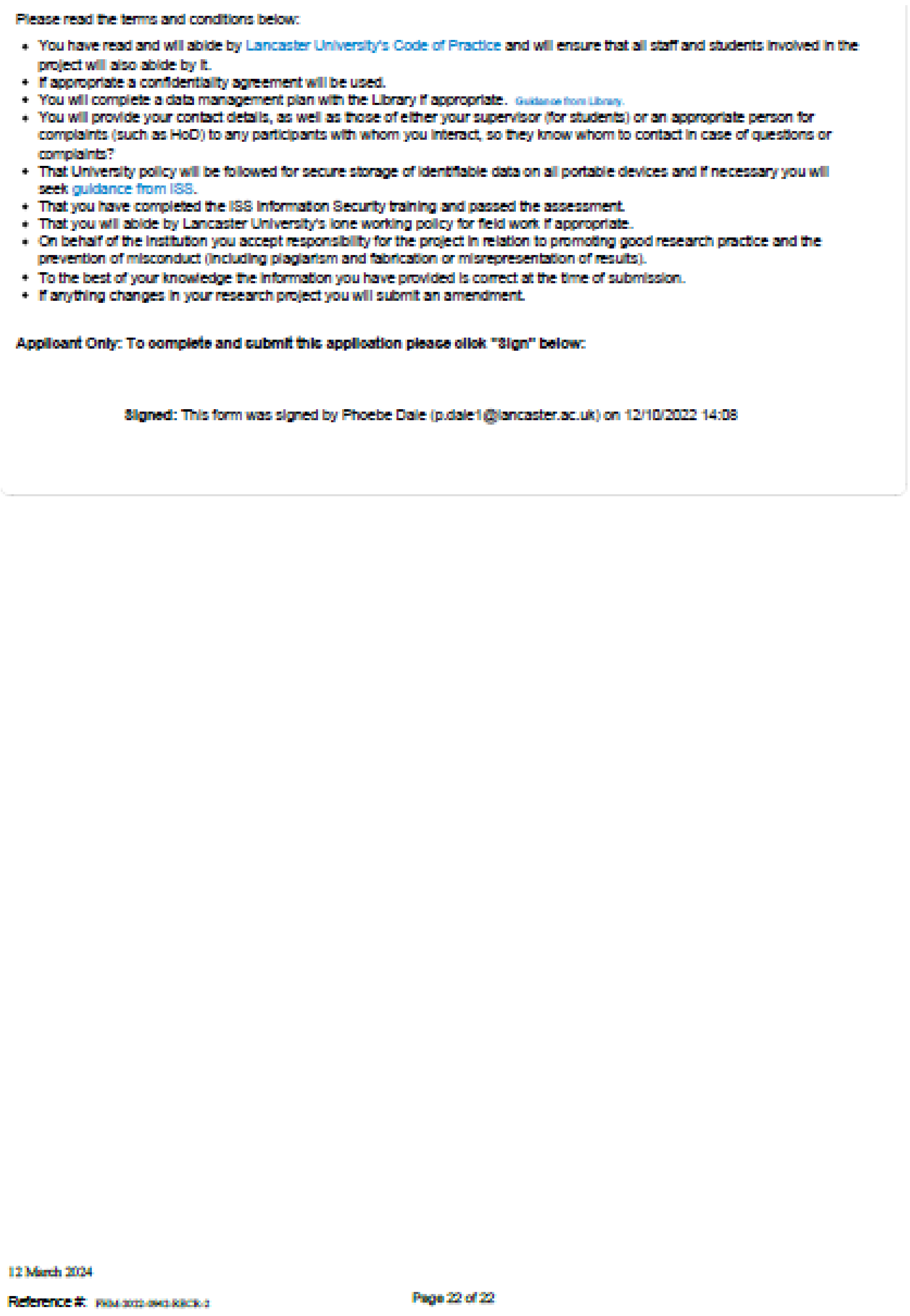
☑ I confirm that I have read and will comply with the LU Data Storage and Governance guidance and that my data use and storage plans comply with the General data Protection Regulation (GDPR) and the UK Data Protection Act 2018.

Have you that you have undertaken a health and safety risk assessment for your project through your departmental process? (Health and Safety Guidance)

☑ I have undertaken a health and safety assesment for your project through my departmental process, and where required will follow the appropriate guidance for the control and management of any foreseeable risks.

When you are satisfied that this application has been completed please click "Request" below to send this application to your supervisor for approval.

**Signed:** This form was signed by Dr Sarah Parry (s.l.parry@lancaster.ac.uk) on 12/10/2022 11:00



Please read the terms and conditions below:

- You have read and will abide by Lancaster University's Code of Practice and will ensure that all staff and students involved in the project will also abide by it.
- If appropriate a confidentiality agreement will be used.
- You will complete a data management plan with the Library if appropriate. Guidance from Library.
- You will provide your contact details, as well as those of either your supervisor (for students) or an appropriate person for complaints (such as HoD) to any participants with whom you interact, so they know whom to contact in case of questions or complaints?
- That University policy will be followed for secure storage of identifiable data on all portable devices and if necessary you will seek guidance from ISS.
- That you have completed the ISS Information Security training and passed the assessment.
- That you will abide by Lancaster University's lone working policy for field work if appropriate.
- On behalf of the institution you accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- To the best of your knowledge the information you have provided is correct at the time of submission.
- If anything changes in your research project you will submit an amendment.

**Applicant Only: To complete and submit this application please click "Sign" below:**

**Signed:** This form was signed by Phoebe Dale (p.dale1@lancaster.ac.uk) on 12/10/2022 14:08

12 March 2024

**Reference #:** [illegible]

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## Appendix 4-A: Research Protocol

## Research Protocol

**Title:**

Exploring Experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder.

**Name of Applicant**

Phoebe Dale – Trainee Clinical Psychologist

**Supervisor**

Dr. Sarah Parry – Clinical Psychologist

**Collaborator**

XXXXXXXX, Trainee Clinical Psychologist

### Introduction

Multisensory experiences broadly refer to the unusual experiences that emerge discretely in more than one sensory modality (Toh et al., 2021). For example, auditory verbal hallucinations, the phenomenon of hearing voices in the absence of a speaker (Moseley et al., 2013). Baumeister et al (2017) proposed conceptualising voice-hearing along a continuum of psychosis. This continuum ranged from sub-clinical populations considered "healthy voice hearers" to those with pronounced clinical difficulties. Voice-hearing during childhood and adolescence is a common and primarily transient developmental feature (Maijer et al., 2017; 2019; Parry et al., 2021b), with 76% of 7-to-8-year-old voice-hearing children stating these experiences had ceased by the age of 12-13 (Bartels-Velthius et al., 2011).

Within this continuum of psychosis are two multisensory experiences which will be the focal point of my thesis project: multiplicity, the experience of having multiple selves that share one physical body, and voice personification, when the voice heard has a distinct personality separate from "the self". The current literature on multiplicity and voice personification in children and adolescents is limited, and additional research is needed to further understand how young people experience them.

Research demonstrates that, when isolated, multiplicity and voice personification can occur without psychological distress (Alderson-Day et al, 2021; Eve & Parry, 2021). However, my Thesis Preparation Assignment (TPA) offered a novel perspective by highlighting that multiplicity and voice personification are difficult to distinguish from one another within childhood and adolescence. Therefore, they may occur simultaneously, with the psychological impact on a young person's wellbeing being unknown. The TPA poses the question that if multiplicity and voice personification are interwoven experiences, is the wider continuum of psychosis more interconnected than a distinct linear spectrum? And if so, do experiences of multiplicity and voice personification interact and contribute to further difficulties within the continuum of psychosis? For example, the Eating Disorder Voice (EDV) is known to play a crucial role in the maintenance of eating disorders as negative eating patterns are related to greater voice power (Pugh & Waller, 2016). It is hypothesised this relationship could be moderated by the individual's belief about the voice and how they respond to it (Pugh, 2016). Improved understanding of the relationship between multiplicity, voice personification, and the EDV could improve psychological interventions that address these maintaining agents of eating disorders e.g. focusing on communication with the voice heard, a common goal within psychological support for multiplicity. Therefore, my Thesis will explore these emerging experiences of multiplicity and voice personification in young women with an eating disorder to further understanding of their relationship to one another.

As previous research has highlighted current language use around eating disorders and distressing sensory experience can feel invalidating for people within services, an experience-based co-design informed methodology (EBCD) will be implemented in this thesis project to develop a common language framework for discussion, ensuring a collaborative procedure that allows space for young women to share their experiences safely, in a supportive environment, to be heard, and appropriately represented through my data collection and analysis.

**Research Questions**

How is emerging multiplicity and voice personification experienced by girls and young women who report the presence of an eating disorder self/part?

**Aims**

My research study aims to explore three types of voice hearing in young women who live with an eating disorder. Multiplicity, the experience of having more than self within the same body, Voice Personification, when the voice heard has its own personality and the Eating Disorder Voice, when the voice says negative things about the person's eating or weight. Voice hearing experiences can make it harder for young women with an eating disorder to get better. I hope by developing a clearer understanding of this experience, we can make recommendations for improving support services.

**Objectives**

We will further our understanding of multiplicity and voice personification in young women who live with an eating disorder by listening to their personal stories. The EBCD informed methodology of this research project provides participants with the space to tell their story and utilises narrative analysis to understand them. The participants involvement is crucial to the EBCD informed methodology and they will provide feedback within a reflective group setting at two different occasions to ensure our analysis is accurately reflecting their experiences.

**Method**

<u>Participants</u>

The following inclusion criteria will be used for participants:

- They self-identify as a woman
- They are aged between 16 and 25 years old.
- They currently or previously experience voice hearing or another multisensory experience.
- Self-identify as currently or previous experience an eating Disorder and self-report voice hearing

The following exclusion criteria will be used for participants:

- Those who identify as a male
- Those who are not within the age range stated above.
- Individuals who have not experienced both an eating disorder and hearing voices or another multisensory experience.

This research aims to obtain participants aged between 16 and 25 years old to capture both "adolescents" and those considered within the "emerging adulthood" age range. There is limited understanding about voice hearing experiences and eating disorders for young people within the current literature, which is why it is important they are included within this research.

The demographic information we will obtain from the participants will include age, gender, ethnicity, and a preferred pseudonym for future use in reports and academic papers (See Appendix M).

Participants will be recruited through the charities Voice Collective and the Hearing Voices Network and Social Media through a twitter account for the research project (@EDVStudy). Please refer to Appendix N for the recruitment advertising. The QR on the advert, also available as a link within the social media posts, will direct participants to Qualtrics. The participants journey is demonstrated in Figure 1. When participants click through to the Qualtrics welcome page, they will be provided with an information sheet (Appendix B). The information sheet outlines the layers of the project, how they can be involved and their rights to withdraw their involvement at any stage. They will be asked if they consent to taking part in the study (see Appendix C). Participants will also be given the option to opt in for updates of the project as it progresses.

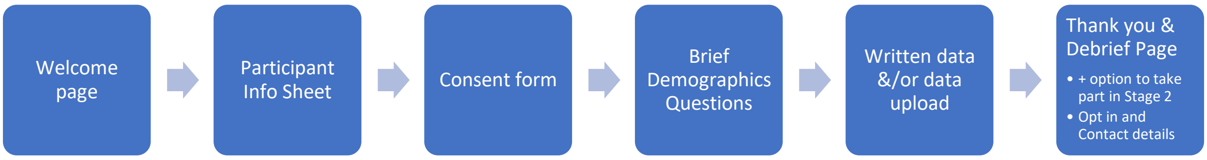


Figure 1. Layer 1 – participant journey

There will be 3 layers within this research project (See Figure 2.). In layer 1 there will be an initial 20 participants. In layer 2 and 3 we aim to have between 8-12 participants either retained from the first layer or obtained through further recruitment. A recent literature review of EBCD studies by Green et al (2020) highlighted that studies on average included between 2-16 participants, with a recommended number of participants being on average five participants per facilitator.

The chosen methodological design is utilised within small scale studies to sustain engagement and establish in-depth understandings of their individual experiences which is why this number of participants has been decided.

## Design

The methodological approach of this research will be informed by Experience Based Co Design informed (EBCD). EBCD brings together narrative-based research with expertise from people with lived experience of mental health and mental health services to further knowledge, collaboration, understanding and service design. This study aims to facilitate the co-design of knowledge of the experience of multisensory experiences and the eating disorder voice. Participants will be invited to submit an individual story to reflect their experience of voice hearing alongside an eating disorder (e.g., Written text, artwork, or poem, etc.), which will facilitate collaboration and provide a richer understanding of this under-researched phenomenon. EBCD uses a narrative approach, which will enable me to develop deeper understandings of lived experience on a personal level, in an impactful yet respectful manner, as studies that have utilised EBCD as a methodology, report participants feeling “listen to” and included (Bowen et al., 2013).

As this is a qualitative research project, we are aware there may be bias within our analysis. Therefore, we aim to create an audit trail which evidences the decision process taken throughout the analysis. The EBCD approach is collaborative in nature, and we will receive feedback from participants to establish whether our initial data analysis accurately represents their experience of multisensory experiences and eating difficulties. Together this will ensure the validity of our study.

Materials

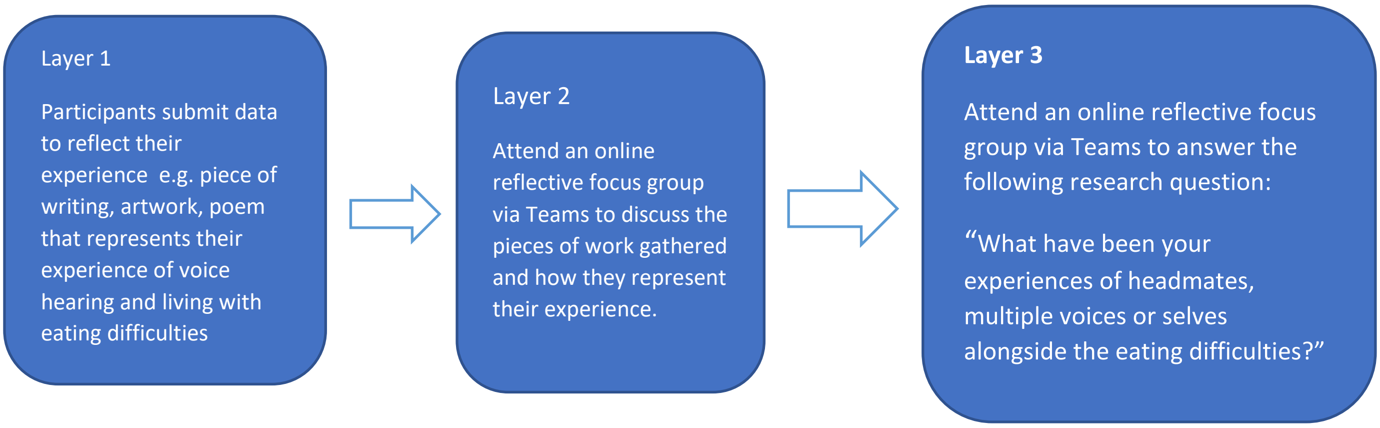
In layer 1 of the research project, we will utilise a Qualtrics questionnaire to obtain consent from participants. The questionnaire will also direct participants of how they can submit their chosen piece of work for the research.

Layers 2 and 3 will comprise of a group reflective group via Microsoft Teams. Within these groups participants will be presented with a stimulus film of the collated pieces of work they have submitted. The reflective groups will follow a semi-structured interview as it allows more space for the participants to discuss their experiences but will aim to obtain their feedback on how accurately our analysis represents their experience. However, due to the nature of the EBCD methodology these discussions within the reflective group will be guided by the participants. The reflective group in layer 3 will focus on answering the specific research question of the study. The themes of this discussion will be surrounding the multisensory experiences of multiplicity, voice personification and the eating disorder voice.

Procedure

*Methodology design and data collection to be partially completed alongside XXXXXX (Trainee Name redacted) as we will use data collected jointly over the first two layers of data collection, followed by a third individual layer to address our research questions. By conducting recruitment and initial layers of data collection together, we can ensure efficient use of participant’s time, reducing burden and minimising participant recruitment challenges.*

There will be three layers within the EBCD informed procedure:



Layer 1

Participants submit data to reflect their experience e.g. piece of writing, artwork, poem that represents their experience of voice hearing and living with eating difficulties

Layer 2

Attend an online reflective focus group via Teams to discuss the pieces of work gathered and how they represent their experience.

**Layer 3**

Attend an online reflective focus group via Teams to answer the following research question:

“What have been your experiences of headmates, multiple voices or selves alongside the eating difficulties?”

Figure 2. Diagram of research project layers

**Layer 1 –** Completed with XXXXXX

We will recruit participants with lived experience of the eating disorder self through social media and community-based support groups (e.g. Voice Collective). A link will be shared through a study specific social media account, which will take participants to a Qualtrics page with details including an information sheet and consent form. In this layer of the research, they will be asked to submit their individual multimodal contributions through Qualtrics (E.g., written text, art work or poem), instructions for how to submit their contribution will be detailed in the Qualtrics page. Upon completion, participants will be asked whether they wish to be involved in layer 2 and layer 3 of the research, with an option to also be kept up to date with the outcomes of the research project.

The first layer of data collection, comprising of the individual contributions, will undergo narrative analysis to form a stimulus film of collective experiences and perspectives. Any audio files submitted will be transcribed and anonymised, following which they will be deleted.

Participants will have 10 working days to withdraw their story from the study following their submission. This is due to the iterative nature of the analysis.

**Layer 2 –** Completed with XXXXXXX

Participants from layer 1 who volunteer for layer 2 will be invited to a live reflective group. Their informed consent for this layer of the research will be obtained prior to the reflective group. The reflective group will be hosted via MS Teams, and facilitated by myself and XXXXXXX. They will be shown the initial stimulus film (Powerpoint/Similar) and general feedback of whether our understanding represents their experiences of voice hearing and eating disorder accurately will be gathered in the form of written notes and discussion. At the end of layer 2 reflective group, participants’ preference of group allocation for layer 3 will be obtained. The audio of the group discussions will be recorded and transcribed verbatim to form the second layer of data collection. It will then be analysed using narrative analysis. This data will be analysed independently by XXXXX and me, in relation to our specific research questions – I will be focusing on the experiences of Multiplicity and Voice Personification alongside Eating Disorder Voices within my analysis.

**Layer 3 –** Completed independently

Participants will be invited back to a second live reflective group, hosted via MS Teams, and facilitated independently. Their informed consent for this layer of the research will be obtained prior to the reflective group. A final stimulus film specifically in relation to experiences of emerging multiplicity and voice personification for girls and young women with an eating disorder will be shown. Feedback and discussion focusing on these two phenomena specifically within the group will form the final data collection process. Discussions will be recorded and transcribed verbatim. All data will be analysed using narrative analysis.

**Proposed Analysis**

A narrative analysis will be completed following both s layer 1, 2 and 3 of the research.

The first narrative analysis will be completed in collaboration with XXXXXX to identify emerging themes within the participant's stories, and guidance sought from both Research tutor and field supervisor. It is this stage of the analysis that will develop the first touchpoint/stimulus film for the reflective group in layer two.

The second and third layers of narrative analysis, will be completed independently under the guidance of my research tutor and field supervisor to address the specific research question of the study.

Narrative analysis has been chosen as it reflects the creative process of the EBCD methodology and constructs a story and narrative from the participants' own personal experiences. Compared to other qualitative analysis, such as Thematic Analysis which breaks down text into smaller codes, Narrative Analysis aims to keep the stories told by participants whole. These form "Narrative blocks" which are compared with other participant's stories to generate core narrative themes (Smith, 2016). There are two strategies used within narrative analysis; Inductive – forming narrative blocks within the data to be compared, or Deductive which takes existing story structures eg. Beginning, middle and end, and picking them out from the data. A combination of the two will allow for a more in-depth comparison across the data and derive key core narratives.

The following analytic framework will be followed:

- Voice notes/Audio recordings will be transcribed, and the text analysed alongside other written stories.
- We will implement Collier's (2001) direct analysis technique for visual data. This involves several stages of analysis: (1) opening viewing all visual data for patterns, (2) categorising the visual data, (3) producing detailed descriptions and, (4) reviewing all visual data.
- All data and the narratives discovered can be simultaneously analysed.

**Practical Issues**

Recruitment and Retention of Participants

Due to the multiple layers of this research project, we are aware there is a risk of attrition between layer, or it could prevent participants from agreeing to participate. Therefore, we are planning to do a prize draw of £25 at the end of each layer to encourage continued engagement. We have also decided to treat each layer individually with its own participation sheet and consent form to allow participants the choice to engage in as much or as little of the research project as they want to. By doing so, it also allows us to reopen recruitment prior to each layer if additional participants are needed for an adequate amount of data for analysis.

Data Storage

Please see Appendix L

The data collected for this study will be stored securely in the University's Onedrive and only the researchers conducting this study and their research supervisor will have access to this data. Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined. All the personal data of participants (Names, Consent forms etc) will be confidential and will be kept separately from the rest of the data. The files on the computers will be encrypted and the computers used to access the data are password protected.

The data will be stored on PURE for 10 years. Dr. Sarah Parry (Research Supervisor) will be the custodian of the data.

### Ethical Concerns

Distress Protocol

This research project is covering topics including eating disorders or hearing voices, which may be distressing for participants to discuss. We have considered the difficulties if someone becomes distressed while attending the online reflective group and how this could be contained (See Appendix K). We have agreed that this will be addressed at the start of the reflective group – we will inform participants of support lines including Voice Collective, Samaritans and NHS 111 and the details of organisations will be posted into the chat function on Microsoft Teams for them to access throughout the reflective group if needed. We will also establish how the group/individual would like to handle distress e.g. having regular check ins and breaks, pausing the group if someone is visibly distressed, time to debrief at the end either as a group or individually and simply being able to leave the group and use the support lines at any point if necessary.

Confidentiality and anonymity

The procedure of our research project involves two reflective groups where participants will discuss the stimulus films as a group. This poses the risk of individual's sharing details of what is discussed outside of the group. To prevent this risk, the reflective groups will begin with setting group rules collaboratively generated by the group of participants in accordance with the NHS guidance on "Running Groups for Patient and Public Engagement. The researchers will ensure an agreement of confidentiality is met by all participants to ensure they feel safe to share personal experiences. The researchers will also remind participants about the limits of confidentiality, therefore if someone discloses information that they will put themselves, another person, or a child at risk of harm we will have a duty of care to discuss this information with the research supervisor. We would ensure participants were informed individually if confidentiality needed to be breached.

### Timescale

- **October 2022 – January 2023** Begin Recruitment and Data collection for layer 1.
- **Jan 2023 – February 2023** First analysis to be completed

- **April 2023 – May 2023** – Recruitment and Data collection for layer 2.
- **June 2023 - August 2023** - Second Analysis of Data
- **June - August 2023** – Recruitment and Data Collection for layer 3.
- **1st September 2023** – Last date of all data collection
- **October – November 2023** – Third Analysis of Data.
- **December 2023** – Write up study.
- **February 2024** – Circulate study summary to participants who opt-in to receive an end of study report
- **May 2024** - Submit thesis

## References

Alderson-Day, B., Woods, A., Moseley, P., Common, S., Deamer, F., Dodgson, G., & Fernyhough, C. (2021). Voice-hearing and personification: characterizing social qualities of auditory verbal hallucinations in early psychosis. *Schizophrenia Bulletin*, *47*(1), 228-236.

Bartels-Velthuis, A. A., van de Willige, G., Jenner, J. A., van Os, J., & Wiersma, D. (2011). Course of auditory vocal hallucinations in childhood: 5-year follow-up study. The British Journal of Psychiatry, 199(4), 296-302

Baumeister, D., Sedgwick, O., Howes, O., & Peters, E. (2017). Auditory verbal hallucinations and continuum models of psychosis: a systematic review of the healthy voice-hearer literature. *Clinical psychology review*, *51*, 125-141.

Collier, M. (2001). Approaches to analysis in visual anthropology. Handbook of visual analysis, 35-60.

Eve, Z., & Parry, S. (2021). Exploring the experiences of young people with multiplicity. *Youth and Policy*.

Green, T., Bonner, A., Teleni, L., Bradford, N., Purtell, L., Douglas, C., ... & Chan, R. J. (2020). Use and reporting of experience-based codesign studies in the healthcare setting: a systematic review. BMJ quality & safety, 29(1), 64-76.

Maijer, K., Hayward, M., Fernyhough, C., Calkins, M. E., Debbané, M., Jardri, R., Kelleher, I., Raballo, A., Rammou, A., & Scott, J. G. (2019). Hallucinations in children and adolescents: an updated review and practical recommendations for clinicians. *Schizophrenia Bulletin*, *45*(Supplement_1), S5-S23.

Maijer, K., Palmen, S. J., & Sommer, I. E. (2017). Children seeking help for auditory verbal hallucinations; who are they? *Schizophrenia Research*, *183*, 31-35.

Moseley, P., Fernyhough, C., & Ellison, A. (2013). Auditory verbal hallucinations as atypical inner speech monitoring, and the potential of neurostimulation as a treatment option. Neuroscience & Biobehavioral Reviews, 37(10), 2794-2805.

Parry, S., Loren, E., & Varese, F. (2021). Young people's narratives of hearing voices: Systemic influences and conceptual challenges. *Clinical Psychology & Psychotherapy*, *28*(3), 715-726.

Pugh, M. (2016). The internal ‘anorexic voice’: a feature or fallacy of eating disorders?. Advances in Eating Disorders, 4(1), 75-83.

Pugh, M., & Waller, G. (2016). The anorexic voice and severity of eating pathology in anorexia nervosa. *International Journal of Eating Disorders*, *49*(6), 622-625.

Smith, B. (2016). Narrative analysis. Analysing qualitative data in psychology, 2, 202-221.

Toh, W. L., Bere, M., & Rossell, S. L. (2021). Distinguishing multimodal versus multisensory hallucinations in psychosis: Key definitions and a way forward. Australian & New Zealand Journal of Psychiatry, 00048674211031455.

### Appendix 4-B – Participant Information Sheet – Layer 1

## Participant Information Sheet – Layer 1

# Exploring voice hearing and multi-sensory experiences with girls and young women who self-report an Eating Disorder Voice

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: [www.lancaster.ac.uk/research/data-protection](www.lancaster.ac.uk/research/data-protection)

### Invitation to research

Hello, our names are XXXXXXX and Phoebe Dale, and we are Clinical Psychology Doctorate trainees at Lancaster University.

Photo of redacted trainee

Our research study aims to develop understanding around voice hearing and multisensory experiences (seeing, hearing, or feeling things that aren't there) with young women who live with an eating disorder. We are particularly interested in experiences of voice hearing in connection with disordered eating, this is sometimes called the Eating Disorder Voice. Voice hearing experiences can make it harder for young women to recover from an eating disorder. We hope by developing a clearer understanding of this experience, we can make recommendations for improving support services.

### Why have I been invited?

You have been invited to take part in this research study as you:

- identify as a young woman.
- are between the ages of 16 and 25 years old.

- Currently or previously experience voice hearing or another multisensory experience, such as visions, feeling the presence of another, or feeling more than one person in one body.
- Currently or previously have experienced an eating disorder.

We are hoping to gather stories of experience from around 20 young women about experiences of voice hearing alongside an eating disorder. You can share your story as a piece of writing, poem, letter, notes, voice note, picture or photos. If you chose to take part, you will have access to a secure online platform where you can safely share your story with the researchers. We will then analyse everyone's stories together to develop a short presentation about the experiences that have been shared. So, please don't share anything you don't want other people to see. We will not include your name or any other identifying information on any outputs from the study, this personal information is confidential. However, we will use the stories shared to create a presentation for discuss, which you and other people with lived experience are welcome to join in layer two, although this data is anonymised, not confidential. This means passages of text and images will be part of the presentation and discussion, but no one will know what you have shared.

**Do I have to take part?**

No. It is completely up to you to decide whether or not you take part. The study will be described, we can go through this information sheet and answer any questions you might have. You will then be asked to sign a consent form which will show you have consented to take part. You are free to withdraw your contribution from the study up to 10 working days after you submitted it. You do not have to give a reason for this.

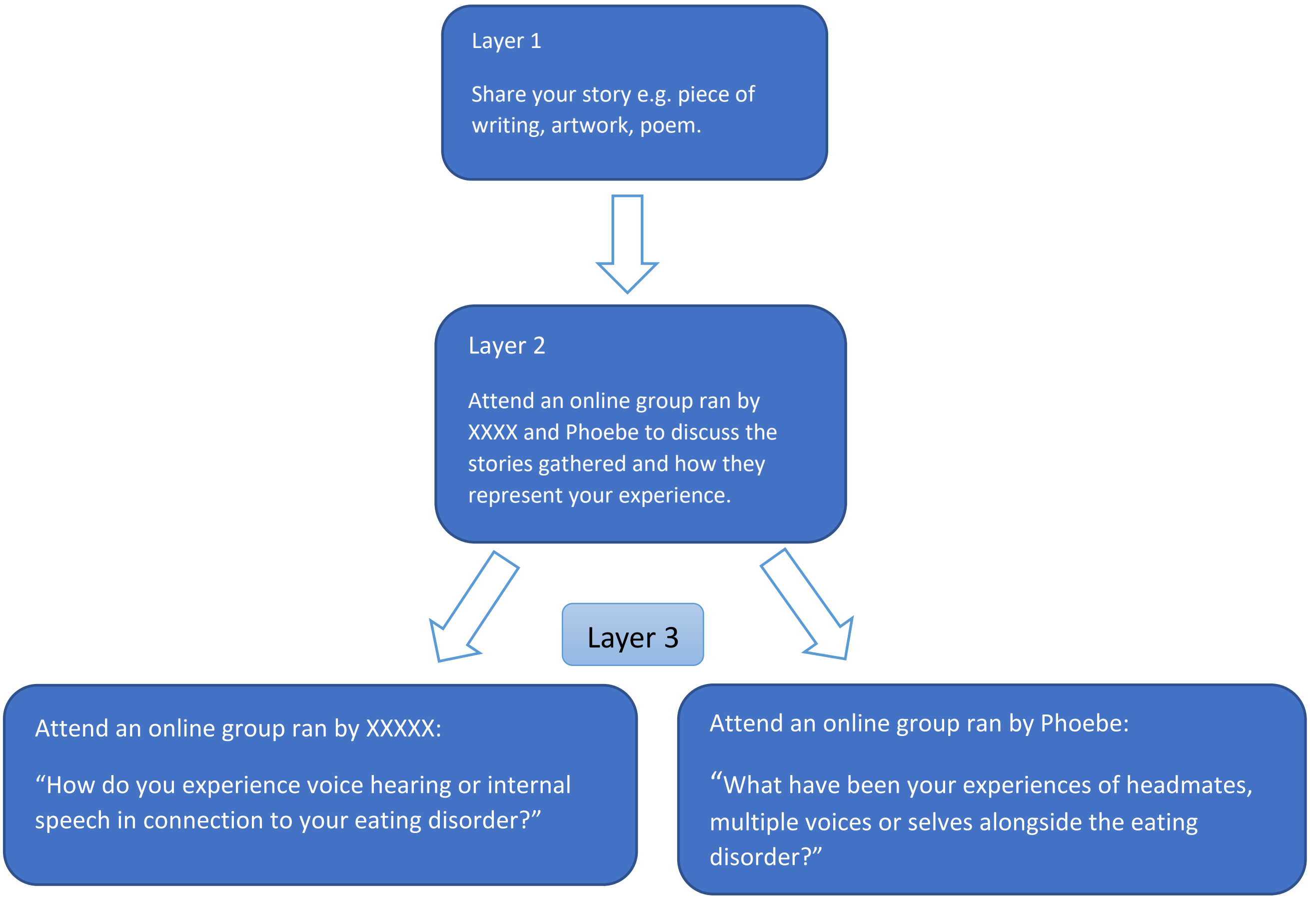
If you do decide to withdraw your consent, please contact the researchers at s.roberts7@lancaster.ac.uk or p.dale1@lancaster.ac.uk. Any personal information taken will be destroyed.

**What will I be asked to do?**

If you have consented to take part in the study, you would be asked to share your story with us via an online platform. You can take part in as much or as little of each of the three layers as you feel comfortable with. This work will reflect your experiences of voice hearing alongside an eating disorder. It is completely up to you what type of work you wish to submit. It could be a piece of writing, artwork, voice note etc. This work along with other participants' work will be made into a short film to represent our findings and interpretations.

If you choose to submit your story, you will then be asked if you would like to take part in further layers of the study. Here is a guideline of the research project's layers:

It is completely up to you to decide whether you take part in any further layers.



Layer 1

Share your story e.g. piece of writing, artwork, poem.

Layer 2

Attend an online group ran by XXXX and Phoebe to discuss the stories gathered and how they represent your experience.

Layer 3

Attend an online group ran by XXXXX:

“How do you experience voice hearing or internal speech in connection to your eating disorder?”

Attend an online group ran by Phoebe:

“What have been your experiences of headmates, multiple voices or selves alongside the eating disorder?”

**Are there any risks?**

If you experience any distress when creating or submitting your story, you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

If you are worried about anything to do with the research study, either before or after taking part, you can contact one of the researchers who will try to answer your questions, or you can contact Voice Collective. Contact details are provided at the bottom of this section.

**Are there any benefits to taking part?**

There is a chance to win £25 for participating in this layer of the research project. The winner will be selected at random after everyone in the study has submitted their story.

You may find participating in the study interesting, and your involvement within this research and the information who share will also help us to further understand how voice hearing and multisensory experiences impact individuals with eating disorders. This will help us to improve the support that services can offer to this community.

**Will my data be identifiable?**

The data collected for this study will be stored securely via University’ Onedrive, and only the researchers conducting this study and their research supervisor will have access to this data.

- Any audio recordings will be destroyed and/or deleted once it has been transcribed.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- Your submitted story will be made anonymous by removing any identifying information including your name. Any voice notes/audio files will be deleted after they have been transcribed and anonymised.
- Anonymised direct quotations from your story may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your submitted piece of work.

There are some limits to confidentiality: if what is included in your piece of work makes us think that you, or someone else, is at significant risk of harm, we will have to break confidentiality and speak to a member of staff about this. If possible, we will tell you if we have to do this.

## What will happen to the results?

At the end of the research study, the results will be summarised and reported in our thesis projects as part of our university course and may be submitted for publication in an academic or professional journal. You will not be identifiable as no names will be used and all information will be anonymised. The findings and some direct quotes from your piece of work might be used in the thesis, in research papers or presentations. You will not be identifiable as no names will be sued and all information will be anonymised.

## Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

## Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researchers:

*Redacted Trainee Name*:

Redacted trainee email address

Phoebe Dale:

p.dale1@lancaster.ac.uk

Alternatively, if you have any concerns and you do not wish to speak to the researchers, you can contact the Research Supervisor:

Dr Sarah Parry
Department of Clinical Psychology
Health Innovation One

Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

s.l.parry@lancaster.ac.uk

**Complaints**
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Ian Smith
Research director
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

Tel: +44 1524 592282
+44 75 078 570 69

Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin
Tel: +44 (0)1524 594973
Chair of FHM REC
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

**THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT**

## Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

**Voice Collective**
Supporting young people who hear, see and sense things others don’t. Non-crisis email, support service, multiple resources www.voicecollective.co.uk
Email: info@voicecollective.co.uk | Tel: 020 7911 0822

**Hearing Voices Network**
National Charity supporting people who hear voices, see visions, or have other unusual sensory perceptions
www.hearing-voices.org/
Email: info@hearing-voices.org

**Samaritans Freephone**
Support line to talk and voice concerns and feelings
116 123

**NHS**
NHS (England) in case of a mental health crisis or emergency
111

## Appendix 4-C – Consent Form - Layer 1

# CONSENT FORM

**Project Title:**
**Exploring Voice Hearing and Multi-sensory experiences with girls and young women who self-report an Eating Disorder Voice**

Name of Researchers: Phoebe Dale and XXXXXXXXXXXXX
Email: pdale1@lancaster.ac.uk and XXXXXXXXXXXXXXXXXXXXXX

**Please tick each box**

| | |
|---|---|
| I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | ☐ |
| I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study without giving any reason. If I withdraw within 10 working days of taking part in the study my data will be removed. | ☐ |
| I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researchers, but my personal information will not be included, and all reasonable steps will be taken to protect the anonymity of the participants involved in this project. | ☐ |
| I consent to information and quotations from my submitted piece of work being used in reports, conferences and training events. | ☐ |
| I understand that data will be kept according to University guidelines for a minimum of 10 years after the end of the study. | ☐ |
| I understand that the researchers will discuss data with their supervisor as needed. | ☐ |
| I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researchers may need to share this information with their research supervisor. | ☐ |
| I agree to take part in the above study. | ☐ |

__________________________ ________________ _________________
Name of Participant Date Signature

**I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.**

**Signature of Researcher /person taking the consent**__________________________ **Date** ___________ Day/month/year

**Signature of Researcher /person taking the consent**____________________________ **Date** ____________ Day/month/year

**One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University**

## Appendix 4-D – Debrief information – Layer 1

### Debrief Information – Layer 1

We would like to thank you for participating in our study.

The prize draw of £25 will take place once all participants have submitted their piece of work. The winner will be selected at random and notified via email. If you would like to enter, please provide your email address below:

__________________________________________________________

Would you like to be kept up to date via your provided email address with the progress of the study?

Yes

No

### What happens next?

As previously mentioned, there are further layers of this study that you may be interested in taking part in. The next layer would involve attending an online group run by XXXXXX and Phoebe to discuss the pieces of work gathered and how they represent your experience

Would you be like to be contacted to take part in further layers of the study via your provided email address?

Yes

No

### Resources in the event of distress

Should you feel distressed, either as a result of taking part, or in the future, the following resources may be of assistance:

**Voice Collective**

Supporting young people who hear, see and sense things others don't. Non-crisis email, support service, multiple resources www.voicecollective.co.uk
Email: info@voicecollective.co.uk | Tel: 020 7911 0822

**Hearing Voices Network**

National Charity supporting people who hear voices, see visions, or have other unusual sensory perceptions

www.hearing-voices.org/

Email: info@hearing-voices.org

**Samaritans Freephone**

Support line to talk and voice concerns and feelings

116 123

**NHS**

NHS (England) in case of a mental health crisis or emergency

111

**Researcher contact details**

If you feel you have been affected by this study and would like to discuss this further, please contact the main researchers:

*Redacted Trainee Contact Details*

Phoebe Dale:

p.dale1@lancaster.ac.uk

Alternatively, if you have any concerns and you do not wish to speak to the researchers, you can contact the Research Supervisor:

Dr Sarah Parry
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

s.l.parry@lancaster.ac.uk

**Complaints**
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Ian Smith
Research director
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

Tel: +44 1524 592282
+44 75 078 570 69

Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin
Tel: +44 (0)1524 594973
Chair of FHM REC
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

## Appendix 4-E – Participant Information Sheet – Layer 2

# Participant Information Sheet – Layer 2

# Exploring voice hearing and multi-sensory experiences with girls and young women who self-report an Eating Disorder Voice.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

### Invitation to research

Hello, our names are XXXXXXXXX and Phoebe Dale, and we are Clinical Psychology Doctorate trainees at Lancaster University.

Photo of redacted trainee

Our research study aims to develop understanding around voice hearing and multisensory experiences (seeing, hearing, or feeling things that aren't there) with young women who live with an eating disorder. We are particularly interested in experiences of voice hearing in connection with disordered eating, this is sometimes called the Eating Disorder Voice. Voice hearing experiences can make it harder for young women to recover from an eating disorder. We hope by developing a clearer understanding of this experience, we can make recommendations for improving support services.

### Why have I been invited?

You have been invited to take part in this research study as you:

- identify as a young woman.
- are between the ages of 16 and 25 years old.
- Currently or previously experience voice hearing or another multisensory experience, such as visions, feeling the presence of another, or feeling more than one person in one body.
- Currently or previously have experienced an eating disorder.

Within this layer of the research, we are hoping to speak to around 8-12 young women with personal experiences of voice hearing experiences alongside their eating disorder so we can understand how this impacts their recovery.

**Do I have to take part?**
No. It is up to you to decide. We will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

If you are involved in the focus group and then withdraw within 10 working days, your data will remain part of the study as it is part of an ongoing conversation and cannot be destroyed. The researchers will try to disregard your views when analysing the focus group data, but this will not always be possible.

If you do decide to withdraw your consent, please contact the researchers at s.roberts7@lancaster.ac.uk or p.dale1@lancaster.ac.uk. Any personal information taken will be destroyed.

**What will I be asked to do?**
If you consent to taking part in this layer of the research study, you will be invited to attend a group discussion online via Microsoft Teams. The discussion would last between one and two hours. You will be asked to watch a short presentation of stories we have gathered including art, poems or pieces of writing and provide feedback on whether it represents your experiences of voice hearing and eating disorder accurately.

If you do not feel comfortable, you do not need to turn your camera on, as we will only be recording the audio of the conversation. Only the researchers will be able to access the recording. We will keep the audio recording until we have written up a transcription of the interview, and then it will be deleted. The write up will not include your name or any personally identifiable details. This is explained more below.

If you choose to take part in layer 2, you will then be asked if you would like to be part of layer 3 of the study, and be taken through the consent process again. If you have consented to be part of layer 3, you will then be asked your preference between two research questions (myself and Phoebe's), i.e. which feels most relevant to you. You will view another short film which will include our findings and interpretations from the feedback given following the first film.

It is completely up to you to decide whether you take part in any further layers.

**Are there any risks?**

If you experience any distress, or don't want to carry on with the group discussion, that is okay and you are able to leave the meeting. There will be information shared at the beginning of the group discussion of support you can access should you need to. You do not have to answer any questions you don't want to within the group discussion.

If you are worried about anything to do with the research study, either before or after taking part, you can contact one of the researchers who will answer all questions, or let you know of additional support available.

**Are there any benefits to taking part?**
There is a chance to win £25 for participating in this layer of the research project. The winner will be selected at random following the online group discussion.
Your involvement within this research and the information who share will also help us to further understand how voice hearing and multisensory experiences impact individuals with eating disorders. This will help us to improve the support that services can offer to this community.

**Will my data be identifiable?**
The data collected for this study will be stored securely in the University's Onedrive and only the researchers conducting this study and their research supervisor will have access to this data.

- Any audio recordings will be destroyed and/or deleted once it has been transcribed.
- The files on the computer will be encrypted (that is no-one other than the researchers will be able to access them) and the computer itself is password protected.
- The typed transcript of the group discussion will be made anonymous by removing any identifying information including your name.
- Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from the group discussion transcription.
- There are some limits to confidentiality: if what is said within the group discussion makes us think you, or someone else, is at significant risk of harm, we will have to break confidentiality and speak to a member of staff about this. If possible, we will tell you if we have to do this.

**What will happen to the results?**
At the end of the research study, the results will be summarised and reported in our thesis projects as part of our university course and may be submitted for publication in an academic or professional journal. You will not be identifiable as no names will be used and all information will be anonymised. The findings and some direct quotes from the group discussion work might be used in the thesis, in research papers or presentations. You will not be identifiable as no names will be used and all information will be anonymised.

**Who has reviewed the project?**
This research project has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

**Where can I obtain further information about the study if I need it?**

If you have any questions about this study, please contact the main researchers:
Phoebe Dale:
p.dale1@lancaster.ac.uk

*Redacted Trainee Details*

Alternatively, if you have any concerns and you do not wish to speak to the researchers, you can contact the Research Supervisor:

Dr Sarah Parry
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW
s.l.parry@lancaster.ac.uk

**Complaints**
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researchers, you can contact:
Ian Smith
Research director
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

Tel: +44 1524 592282
+44 75 078 570 69

Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin
Tel: +44 (0)1524 594973
Chair of FHM REC
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

## THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

**Resources in the event of distress:**
Should you feel distressed as a result of taking part, or in the future, the following resources may be of assistance.

**Voice Collective**
Supporting young people who hear, see and sense things others don't. Non-crisis email, support service, multiple resources www.voicecollective.co.uk
Email: info@voicecollective.co.uk | Tel: 020 7911 0822

**Hearing Voices Network**
National Charity supporting people who hear voices, see visions, or have other unusual sensory perceptions
www.hearing-voices.org/
Email: info@hearing-voices.org

**Samaritans Freephone**
Support line to talk and voice concerns and feelings
116 123

**NHS**
NHS (England) in case of a mental health crisis or emergency
111

## Appendix 4-F – Consent Form – Layer 2

# CONSENT FORM

**Project Title:**
**Exploring Voice Hearing and Multi-sensory experiences with girls and young women who self-report an Eating Disorder Voice**

Name of Researchers: Phoebe Dale and XXXXXXXXX
Email: pdale1@lancaster.ac.uk and XXXXXXXXXXXXX
**Please tick each box**

| | |
|---|---|
| I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | ☐ |
| I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study without giving any reason. If I am involved in focus groups and then withdraw within 10 working days, my data will remain part of the study. I understand that as part the focus group I will take part in, my data is part of the ongoing conversation and cannot be destroyed. I understand that the researchers will try to disregard my views when analysing the focus group data, but I am aware that this will not always be possible. | ☐ |
| If I am participating in the focus group, I understand that any information disclosed within the focus group remains confidential to the group, and I will not discuss the focus group with or in front of anyone who was not involved unless I have the relevant person's express permission. | ☐ |
| I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researchers, but my personal information will not be included, and all reasonable steps will be taken to protect the anonymity of the participants involved in this project. | ☐ |
| I consent to information and quotations from the focus group being used in reports, conferences and training events. | ☐ |
| I understand that the focus group will be audio-recorded and transcribed, and that data will be protected on encrypted devices and kept secure. | ☐ |
| I understand that data will be kept according to University guidelines for a minimum of 10 years after the end of the study. | ☐ |
| I understand that the researchers will discuss data with their supervisor as needed. | ☐ |
| I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researchers may need to share this information with their research supervisor. | ☐ |
| I agree to take part in the above study. | ☐ |

_________________________ _______________ _________________
Name of Participant Date Signature

**I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.**

**Signature of Researcher ___________________________ Date ___________** Day/month/year

**Signature of Researcher ___________________________ Date ___________** Day/month/year

**One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University.**

## Appendix 4-G – Debrief Information – Layer 2

### Debrief Information Layer 2

We would like to thank you for participating in our study.

The prize draw of £25 will take place following the focus group. The winner will be selected at random and notified via email. If you would like to enter, please provide your email address below:

Would you like to be kept up to date via your provided email address with the progress of the study?

Yes
No

### What happens next?

As previously mentioned, there are further layers of this study that you may be interested in taking part in. The next layer would involve attending an online group run by either XXXXXX or Phoebe to discuss the pieces of work gathered and how they represent your experience, in relation to one of two different research questions.

Would you be like to be contacted to take part in further layers of the study via your provided email address?
Yes
No

### Resources in the event of distress

Should you feel distressed, either as a result of taking part, or in the future, the following resources may be of assistance:

**Voice Collective**
Supporting young people who hear, see and sense things others don't. Non-crisis email, support service, multiple resources www.voicecollective.co.uk

**Hearing Voices Network**
National Charity supporting people who hear voices, see visions, or have other unusual sensory perceptions
www.hearing-voices.org/
Email: info@hearing-voices.org

**Samaritans Freephone**

Support line to talk and voice concerns and feelings
116 123

**NHS**
NHS (England) in case of a mental health crisis or emergency
111

**Researcher contact details**

If you feel you have been affected by this study and would like to discuss this further, please contact the main researchers:

*Redacted Trainee Contact Details*

Phoebe Dale:
p.dale1@lancaster.ac.uk

Alternatively, if you have any concerns and you do not wish to speak to the researchers, you can contact the Research Supervisor:
Dr Sarah Parry
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW
s.l.parry@lancaster.ac.uk

**Complaints**
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:
Ian Smith
Research director
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

Tel: +44 1524 592282
+44 75 078 570 69

Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Dr Laura Machin
Tel: +44 (0)1524 594973
Chair of FHM REC
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

**Appendix 4-H – Participant Information Sheet – Layer 3**

# Participant Information Sheet – Layer 3

## Exploring experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

### Invitation to research

Hello, my name is Phoebe Dale, and I am a Clinical Psychology Doctorate trainee at Lancaster University.

My research study aims to explore three types of voice hearing in young women who live with an eating disorder. Multiplicity, the experience of having more than person within the same body, Voice Personification, when the voice heard has its own personality and the Eating Disorder Voice, when the voice says negative things about the person's eating or weight. Voice hearing experiences can make it harder for young women to recover from an eating disorder. I hope by developing a clearer understanding of this experience, we can make recommendations for improving support services.

### Why have I been invited?

You have been invited to take part in this research study as you:

- identify as a young woman.
- are between the ages of 16 and 25 years old.
- Currently or previously experience voice hearing or another multisensory experience, such as visions, feeling the presence of another, or feeling more than one person in one body.
- Currently or previously have experienced an eating disorder.

Within this layer of the research, I am hoping to speak to around 8-12 young women with personal experiences of voice hearing experiences alongside their eating disorder in an online group so we can understand how this impacts their recovery. We will discuss the stories that we have analysed so far and ask for your feedback on how well these represent your own experience.

**Do I have to take part?**

It is up to you to decide. We will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

If you are involved in the focus group and then withdraw within 10 working days, your data will remain part of the study as it is part of the ongoing conversation and cannot be destroyed. The researchers will try to disregard your views when analysing the focus group data, but this will not always be possible.

If you do decide to withdraw your consent, please contact the researcher at p.dale1@lancaster.ac.uk. Any personal information taken will be destroyed.

**What will I be asked to do?**

If you consent to taking part in this layer of the research study, you will be invited to attend a group discussion online via Microsoft Teams. You do not need a Microsoft Teams account for this. The discussion would last between one and two hours. You will be asked to watch a short presentation of our findings and interpretations from the stories we have gathered, and feedback provided in a previous group discussion. Following which, you will be asked to provide feedback on whether it accurately represents your experiences of multiplicity, voice personification or the eating disorder voice alongside an eating disorder.

If you do not feel comfortable, you do not need to turn your camera on, as we will only be recording the audio of the conversation. Only the researchers will be able to access the recording. We will keep the audio recording until we have written up a transcription of the interview, and then it will be deleted. The write up will not include your name or any personally identifiable details. This is explained more below.

**Are there any risks?**

If you get upset, or don’t want to carry on with the group discussion, that is okay and you are able to leave the meeting. There will be information shared at the beginning of the group discussion of support you can access should you need to. You do not have to answer any questions you don’t want to within the group discussion.

If you are worried about anything to do with the research study, either before or after taking part, you can contact one of the researchers who will answer all questions, or let you know of additional support available.

**Are there any benefits to taking part?**

There is a chance to win £25 for participating in this layer of the research project. The winner will be selected at random following the online group discussion.

Your involvement within this research and the information who share will also help us to further understand how voice hearing and multisensory experiences impact individuals with eating disorders. This will help us to improve the support that services can offer to this community.

**Will my data be identifiable?**

The data collected for this study will be stored securely in the University's Onedrive and only the researchers conducting this study and their research supervisor will have access to this data.

- Audio recordings will be destroyed and/or deleted once they have been transcribed.
- The files on the computer will be encrypted (that is no-one other than the researchers will be able to access them) and the computer itself is password protected.
- The typed transcript of the group discussion will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from the group discussion transcription.

There are some limits to confidentiality: if what is said within the group discussion makes us think you, or someone else, is at significant risk of harm, we will have to break confidentiality and speak to a member of staff e.g. our supervisor about this. If possible, we will tell you if we have to do this.

**What will happen to the results?**

At the end of the research study, a write up of the findings will make up part of the final report/thesis. It may be submitted for publication in an academic or professional journal. The findings and some direct quotes from the group discussion might be used in the thesis, in research papers or presentations. You will not be identifiable as no names will be sued and all information will be anonymised.

**Who has reviewed the project?**

This research project has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

**Where can I obtain further information about the study if I need it?**

If you have any questions or concerns about this study, please contact either of the lead researcher in the first instance:

Phoebe Dale:

p.dale1@lancaster.ac.uk

Alternatively, if you have any concerns and you do not wish to speak to the researchers, you can contact the Research Supervisor

Dr Sarah Parry
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

s.l.parry@lancaster.ac.uk

**Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researchers, you can contact:

Ian Smith
Research director
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

Tel: +44 1524 592282
+44 75 078 570 69

Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin
Tel: +44 (0)1524 594973
Chair of FHM REC
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University

Lancaster
LA1 4YG

## THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

**Resources in the event of distress:**

Should you feel distressed as a result of taking part in this research the following resources may be of assistance.

**Voice Collective**
Supporting young people who hear, see and sense things other don’t. They offer a non-crisis email address, support service, and have multiple resources available online
www.voicecollective.co.uk
Email: info@voicecollective.co.uk | Tel: 020 7911 0822

**Hearing Voices Network**
National Charity supporting people who hear voices, see visions, or have other unusual sensory perceptions
www.hearing-voices.org/
Email: info@hearing-voices.org

**Samaritans Freephone**
Support line to talk and voice concerns and feelings
116 123

**NHS**
NHS (England) in case of a mental health crisis or emergency
111

## Appendix 4-I– Consent Form – Layer 3

# CONSENT FORM

Lancaster University

**Project Title:**
**Exploring experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder**

Name of Researchers: Phoebe Dale
Email: pdale1@lancaster.ac.uk
**Please tick each box**

| | |
|---|---|
| I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | ☐ |
| I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study, without giving any reason. If I am involved in focus groups and then withdraw within 10 working days, my data will remain part of the study. I understand that as part the focus group I will take part in, my data is part of the ongoing conversation and cannot be destroyed. I understand that the researcher will try to disregard my views when analysing the focus group data, but I am aware that this will not always be possible. | ☐ |
| If I am participating in the focus group, I understand that any information disclosed within the focus group remains confidential to the group, and I will not discuss the focus group with or in front of anyone who was not involved unless I have the relevant person's express permission. | ☐ |
| I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher, but my personal information will not be included, and all reasonable steps will be taken to protect the anonymity of the participants involved in this project. | ☐ |
| I consent to information and quotations from the focus group being used in reports, conferences and training events. | ☐ |
| I understand that the focus group will be audio-recorded and transcribed, and that data will be protected on encrypted devices and kept secure. | ☐ |
| I understand that data will be kept according to University guidelines for a minimum of 10 years after the end of the study. | ☐ |
| I understand that the researcher will discuss data with their supervisor as needed. | ☐ |
| I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researchers may need to share this information with their research supervisor. | ☐ |
| I agree to take part in the above study. | ☐ |

______________________ ________________ _________________
Name of Participant Date Signature

**I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.**

**Signature of Researcher ___________________________ Date ___________** Day/month/year

**One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University.**

## Appendix 4-J – Debrief Sheet – Layer 3

### Debrief Information - Layer 3

I would like to thank you for participating in my study.

The prize draw of £25 will take place following the focus group. The winner will be selected at random and notified via email. If you would like to enter, please provide your email address below:

Would you like to be kept up to date via your provided email address with the progress of the study?

Yes
No

### What happens next?

The final layer of the study has now finished. If you have consented, you will be kept up to date with the progress and the findings of the study once it has been published/examined.

### Resources in the event of distress

Should you feel distressed, either as a result of taking part, or in the future, the following resources may be of assistance:

**Voice Collective**
Supporting young people who hear, see and sense things others don’t. Non-crisis email, support service, multiple resources www.voicecollective.co.uk

**Hearing Voices Network**
National Charity supporting people who hear voices, see visions, or have other unusual sensory perceptions
www.hearing-voices.org/
Email: info@hearing-voices.org

**Samaritans Freephone**
Support line to talk and voice concerns and feelings
116 123

**NHS**
NHS (England) in case of a mental health crisis or emergency
111

**Researcher contact details**

If you feel you have been affected by this study and would like to discuss this further, please contact the main researcher:
Phoebe Dale
p.dale1@lancaster.ac.uk

Alternatively, if you have any concerns and you do not wish to speak to the researcher, you can contact the Research Supervisor:
Dr Sarah Parry
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW
s.l.parry@lancaster.ac.uk

**Complaints**
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:
Ian Smith
Research director
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW

Tel: +44 1524 592282
+44 75 078 570 69

Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Dr Laura Machin
Tel: +44 (0)1524 594973
Chair of FHM REC
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

## Appendix 4-K - Distress Protocol: Managing distress within a research focus group

Before the group begins, researchers will discuss the following with participants:

- Confidentiality and its limits
- Being able to remain anonymous if they wish to by keeping their cameras turned off
- How they are able to contact us if they become distressed e.g. sending a direct message on MS Teams or emailing us

Further group rules will be outlined through discussion with participants.

**Distress**

- a participant indicates they are experiencing emotional distress
- a participant displays behaviours suggesting they are experiencing distress e.g. crying, withdrawn

**Researcher response**

- pause the group
- check in with participant
- ask what may be helpful to manage distress

**Review**

- ask participant if they feel able to continue with the group
- if they feel able to, continue with group
- if they do not feel able to, enable participant to leave the group
- offer follow up check in if appropriate and participant consents

**Researcher response**

- provide follow up check in if they have consented
- signpost to other support services
- provide debrief sheet
- inform them of outcomes of the study if they have consented
- ensure they have researchers' contact details via the PIS for any further queries

## Appendix 4-L – Data Management Plan

# Data Management Plan – Thesis Project

### Data Collection

There will be two different forms of new data collected within this research project:

**Multimodal data** – This will comprise of written pieces, poems, artwork etc. We aim to collect 20 pieces of multimodal data from the participants via online submission.

**Transcriptions** – This data will comprise of two audio recordings of group discussions that will be transcribed by the researchers. The group discussions of approx. 12 participants will be held on Microsoft Teams to record the discussions.

### Documentation and Metadata

The multimodal data obtained will be documented in an excel file. This file will summarise how many of each different type of data (eg. Written pieces, poems, artwork, images, or voice notes) there are within the data set.

### Storage, Backup and Security

The data collected for this study will be stored securely in the University's Onedrive and only the researchers conducting this study and their research supervisor will have access to this data.

Audio recordings will be destroyed and/or deleted once they have been transcribed.

All the personal data of participants (Names, Consent forms etc) will be confidential and will be kept separately from the rest of the data.

The files on the computers will be encrypted and the computers used to access the data are password protected.

The researchers, Phoebe Dale and XXXXXX, will be responsible for backing up the data. The data will be backed up monthly during the data collection layers onto a removeable hard drive. The backups will be destroyed upon submission of the project.

### Ethics and Legal Compliance

Any ethical issues raised by either participant, researchers, or the research supervisor will be initially discussed within the research team. These will then be discussed with the Research Director in the Department of Clinical Psychology at Lancaster University, Ian Smith, and the appropriate recommendations followed to manage any ethical issues.

## Selection and Preservation

Following submission, the data obtained will be stored in PURE for 10 years.

## Data Sharing

Our data set will not be shared due to the unique identifiers in elements of our data. As part of the informed consent, participants will be asked if they are happy for some or all of their multimodal data, whether visual or written, to be used for publication and dissemination purposes.

## Responsibilities and Resources

The responsibilities of data management are with the researchers conducting this project, Phoebe Dale and XXXXXXX, and supervisor of this project, Dr. Sarah Parry.

## Appendix 4-M – Demographic Questions

### Demographic Questions

*These questions will be included in the Qualtrics Questionnaire and repeated at each layer of the research project.*

**Please fill in the following questions regarding your demographics:**

What gender do you identify with?

Male

Female

Non-binary/third gender

Prefer not to say

What is your age?

______________________

What is your ethnic origin?

_______________________

Which area do you live in (e.g. region, city or county)

________________________________

If you'd like to create a preferred pseudonym (false name) that we can use to protect your anonymity in future reports and academic papers, please state it below:

_________________________

How would you describe your Eating Disorder?

________________________

How long have you lived with your Eating Disorder?

________________________

Have you ever accessed mental health support for your Eating Disorder, if so what support did you receive?

______________________________

How would you describe your experience of hearing voices?

________________________________

How long have you been experiencing voice hearing?

________________________________

Are you currently experiencing voice hearing?

_________________________________

Have you experienced other multisensory experiences (e.g. seeing, hearing, feeling things that aren't there), if so please describe below.

_______________________________

How long have you had these multisensory experiences?

_______________________________

Are you currently having these multisensory experiences?

_______________________________

## Appendix 4-N – Advertising Materials

### Layer 1

Exploring Voice Hearing in Eating Disorders

Stage 1

Postgraduate research project

Any questions, contact Sarah or Phoebe
s.roberts7@lancaster.ac.uk
p.dale1@lancaster.ac.uk

16-25 years old? Do you also identify as a woman?

Experienced hearing voices, feeling more than one self or another multi-sensory experience?

Have you ever lived with an eating disorder?

We want to hear your story!

QR Code will be inserted here

Survey link

### Layer 2

Exploring Voice Hearing in Eating Disorders

Stage 2 – Feedback Groups

Postgraduate research project

Any questions, contact Sarah or Phoebe:
s.roberts7@lancaster.ac.uk
p.dale1@lancaster.ac.uk

Are you a 16- 25 year old woman?

Experienced hearing voices, or another multi-sensory experience?

Have you ever lived with an eating disorder?

Would you like to take part in a group discussion of your experience? If so follow the link!

QR Code will be inserted here

Survey link

## Layer 3

Multiplicity

Plurality

Head mates

Multiple selves

Exploring the experience of multiple voices/selves in Eating Disorders

Postgraduate research project

Any questions about the study – please contact Phoebe on:
p.dale1@lancaster.ac.uk

Do any of these words above describe your experience of hearing voices?

Are you a 16- 25 year old woman?

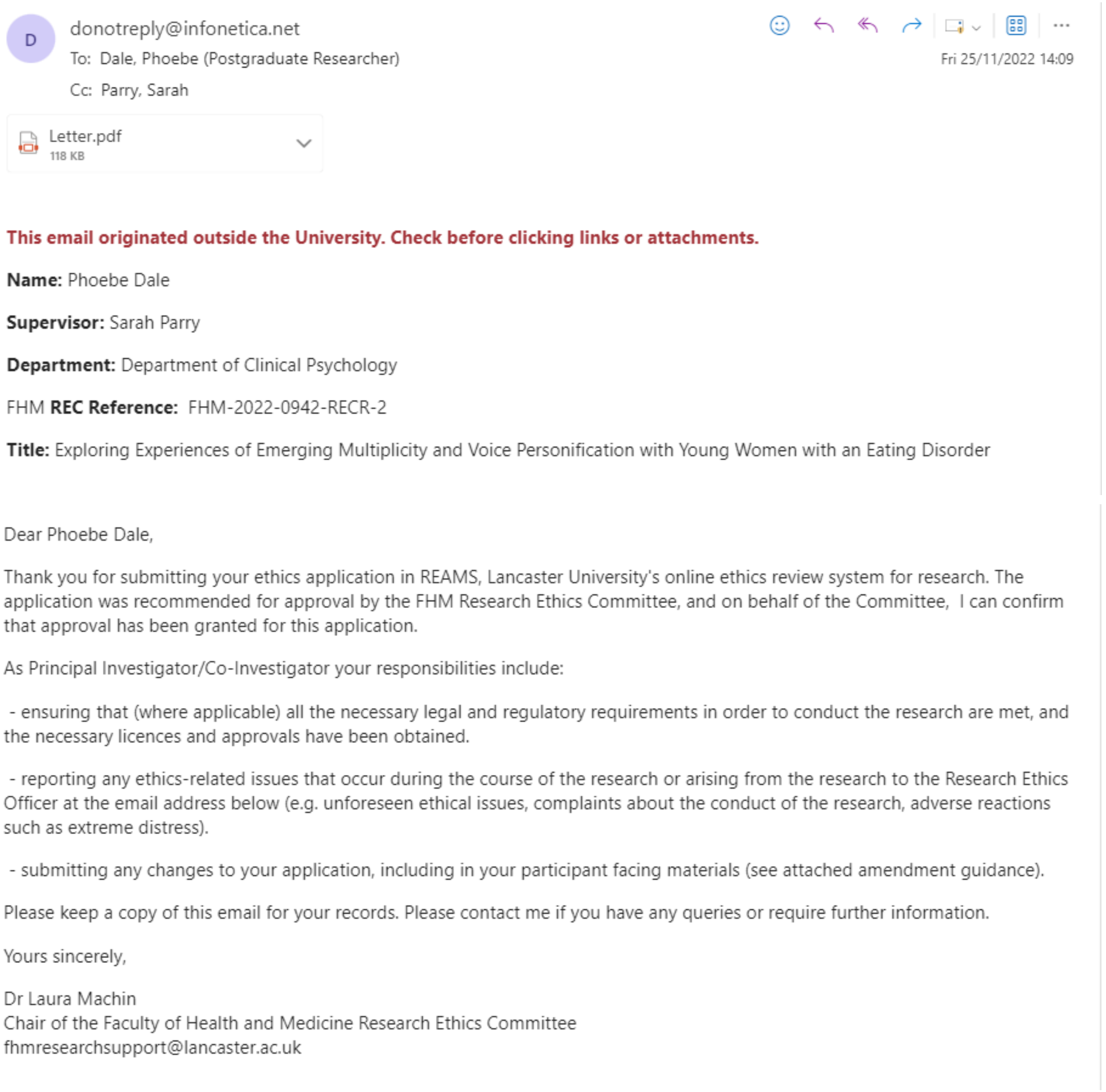
Have you ever lived with an eating disorder?

Would you like to take part in a group discussion, via Microsoft Teams, of your experience? If so follow the link!

QR Code will be inserted here

Survey link

## Appendix 4-O – Approval Email



donotreply@infonetica.net

To: Dale, Phoebe (Postgraduate Researcher)

Cc: Parry, Sarah

Fri 25/11/2022 14:09

Letter.pdf
118 KB

**This email originated outside the University. Check before clicking links or attachments.**

**Name:** Phoebe Dale

**Supervisor:** Sarah Parry

**Department:** Department of Clinical Psychology

FHM **REC Reference:** FHM-2022-0942-RECR-2

**Title:** Exploring Experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder

Dear Phoebe Dale,

Thank you for submitting your ethics application in REAMS, Lancaster University's online ethics review system for research. The application was recommended for approval by the FHM Research Ethics Committee, and on behalf of the Committee, I can confirm that approval has been granted for this application.

As Principal Investigator/Co-Investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licences and approvals have been obtained.

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress).

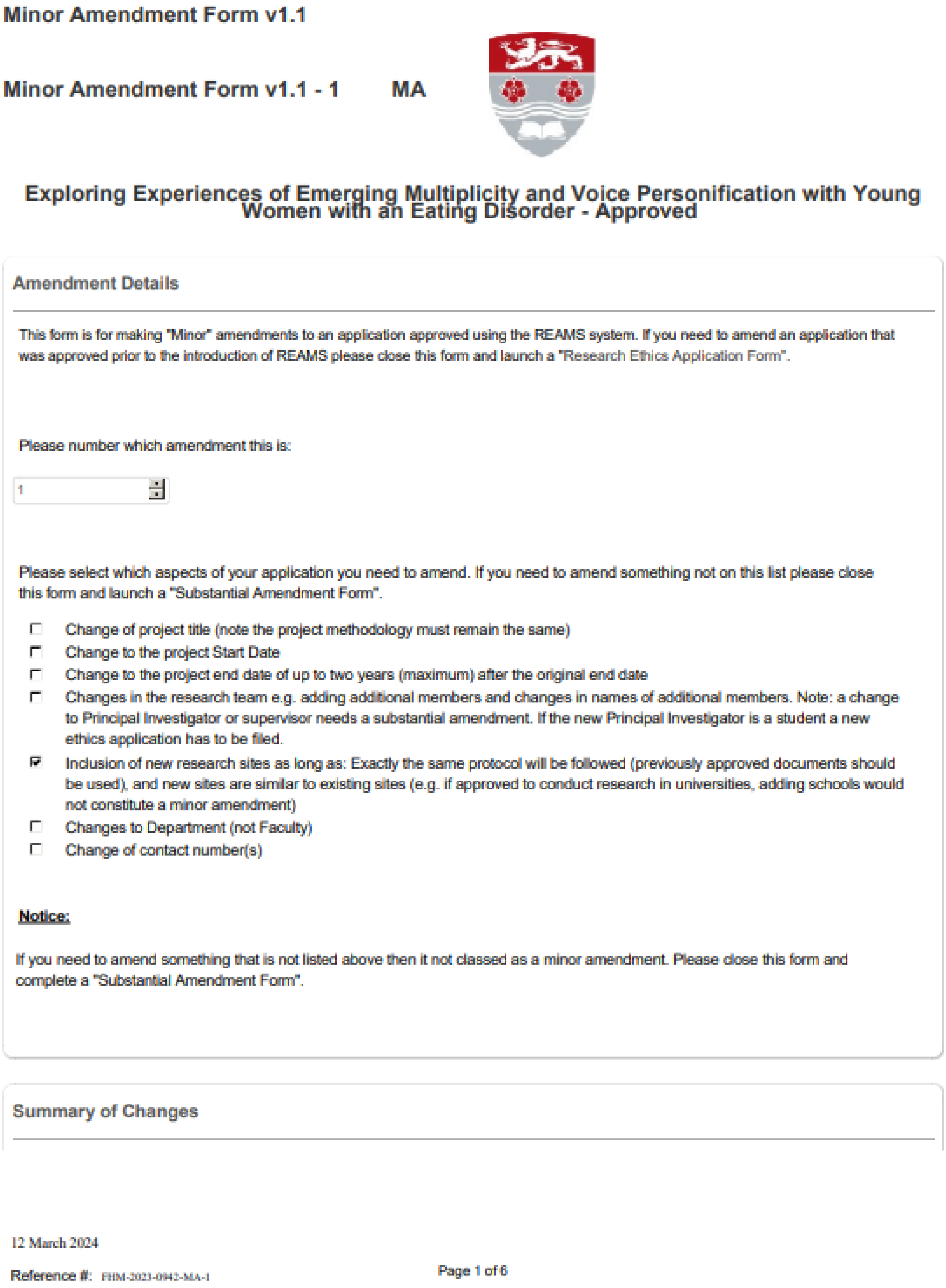
- submitting any changes to your application, including in your participant facing materials (see attached amendment guidance).

Please keep a copy of this email for your records. Please contact me if you have any queries or require further information.

Yours sincerely,

Dr Laura Machin
Chair of the Faculty of Health and Medicine Research Ethics Committee
fhmresearchsupport@lancaster.ac.uk

## Appendix 4-P – Amendment Application



**Minor Amendment Form v1.1**

**Minor Amendment Form v1.1 - 1 MA**

**Exploring Experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder - Approved**

**Amendment Details**

This form is for making "Minor" amendments to an application approved using the REAMS system. If you need to amend an application that was approved prior to the introduction of REAMS please close this form and launch a "Research Ethics Application Form".

Please number which amendment this is:

1

Please select which aspects of your application you need to amend. If you need to amend something not on this list please close this form and launch a "Substantial Amendment Form".

- ☐ Change of project title (note the project methodology must remain the same)
- ☐ Change to the project Start Date
- ☐ Change to the project end date of up to two years (maximum) after the original end date
- ☐ Changes in the research team e.g. adding additional members and changes in names of additional members. Note: a change to Principal Investigator or supervisor needs a substantial amendment. If the new Principal Investigator is a student a new ethics application has to be filed.
- ☑ Inclusion of new research sites as long as: Exactly the same protocol will be followed (previously approved documents should be used), and new sites are similar to existing sites (e.g. if approved to conduct research in universities, adding schools would not constitute a minor amendment)
- ☐ Changes to Department (not Faculty)
- ☐ Change of contact number(s)

**Notice:**

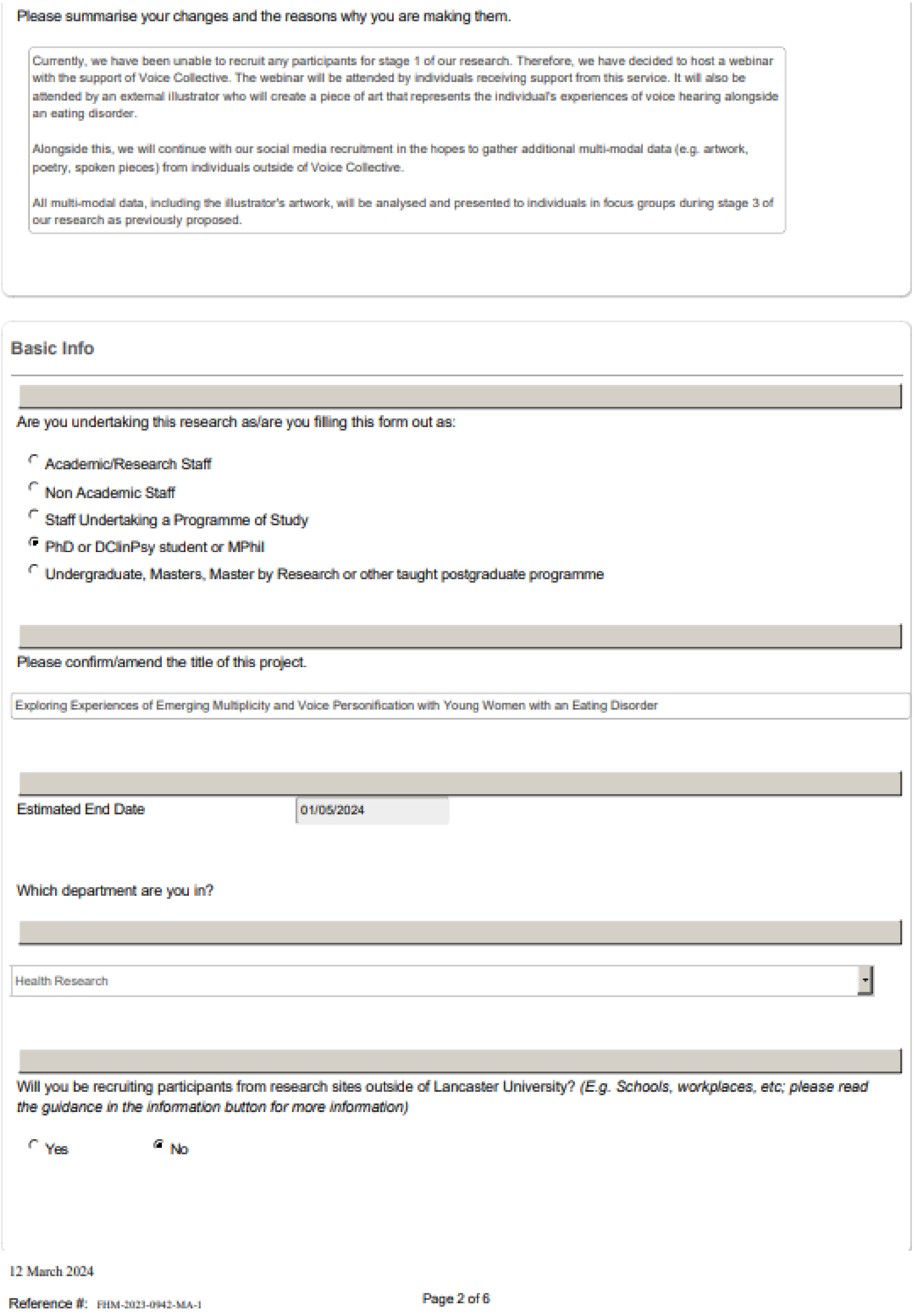
If you need to amend something that is not listed above then it not classed as a minor amendment. Please close this form and complete a "Substantial Amendment Form".

**Summary of Changes**

12 March 2024

Reference #: FHM-2023-0942-MA-1

Page 1 of 6



Please summarise your changes and the reasons why you are making them.

Currently, we have been unable to recruit any participants for stage 1 of our research. Therefore, we have decided to host a webinar with the support of Voice Collective. The webinar will be attended by individuals receiving support from this service. It will also be attended by an external illustrator who will create a piece of art that represents the individual's experiences of voice hearing alongside an eating disorder.

Alongside this, we will continue with our social media recruitment in the hopes to gather additional multi-modal data (e.g. artwork, poetry, spoken pieces) from individuals outside of Voice Collective.

All multi-modal data, including the illustrator's artwork, will be analysed and presented to individuals in focus groups during stage 3 of our research as previously proposed.

Basic Info

Are you undertaking this research as/are you filling this form out as:

○ Academic/Research Staff
○ Non Academic Staff
○ Staff Undertaking a Programme of Study
● PhD or DClinPsy student or MPhil
○ Undergraduate, Masters, Master by Research or other taught postgraduate programme

Please confirm/amend the title of this project.

Exploring Experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder

Estimated End Date 01/05/2024

Which department are you in?

Health Research

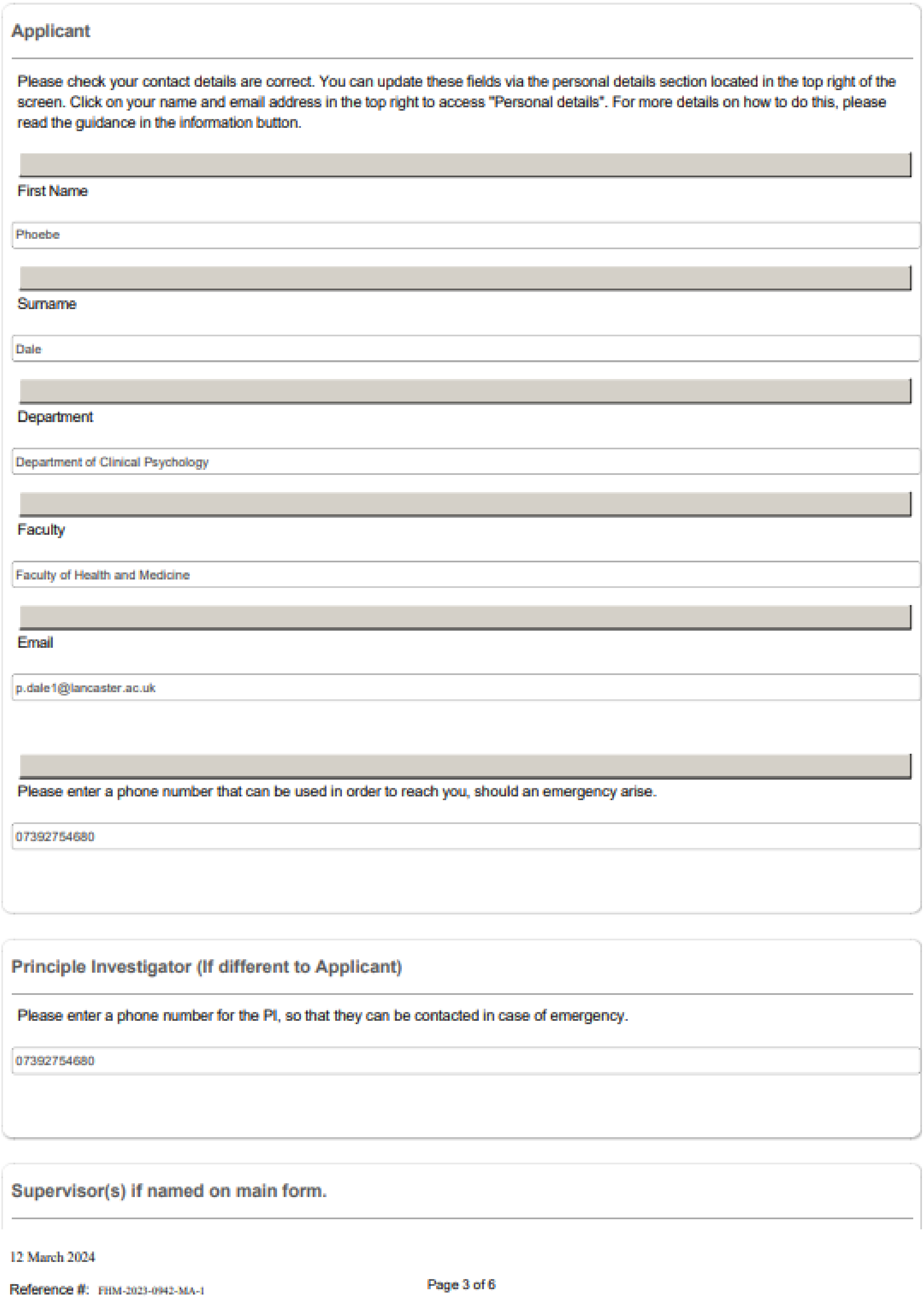
Will you be recruiting participants from research sites outside of Lancaster University? *(E.g. Schools, workplaces, etc; please read the guidance in the information button for more information)*

○ Yes ● No

12 March 2024

Reference #: FHM-2023-0942-MA-1

Page 2 of 6



## Applicant

Please check your contact details are correct. You can update these fields via the personal details section located in the top right of the screen. Click on your name and email address in the top right to access "Personal details". For more details on how to do this, please read the guidance in the information button.

First Name

Phoebe

Surname

Dale

Department

Department of Clinical Psychology

Faculty

Faculty of Health and Medicine

Email

p.dale1@lancaster.ac.uk

Please enter a phone number that can be used in order to reach you, should an emergency arise.

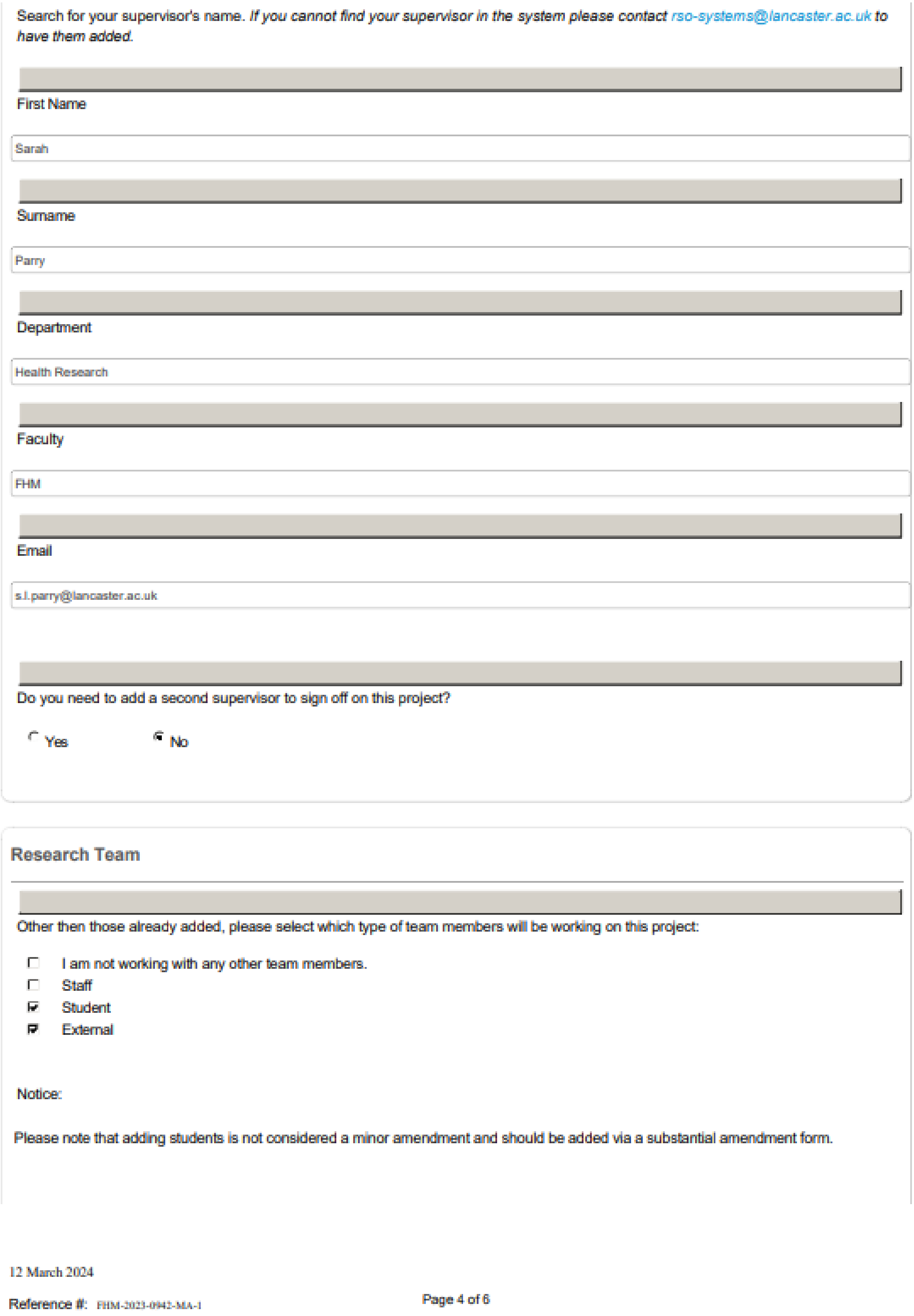
07392754680

## Principle Investigator (If different to Applicant)

Please enter a phone number for the PI, so that they can be contacted in case of emergency.

07392754680

## Supervisor(s) if named on main form.



Search for your supervisor's name. *If you cannot find your supervisor in the system please contact rso-systems@lancaster.ac.uk to have them added.*

First Name

Sarah

Surname

Parry

Department

Health Research

Faculty

FHM

Email

s.l.parry@lancaster.ac.uk

Do you need to add a second supervisor to sign off on this project?

○ Yes ● No

## Research Team

Other then those already added, please select which type of team members will be working on this project:

- ☐ I am not working with any other team members.
- ☐ Staff
- ☑ Student
- ☑ External

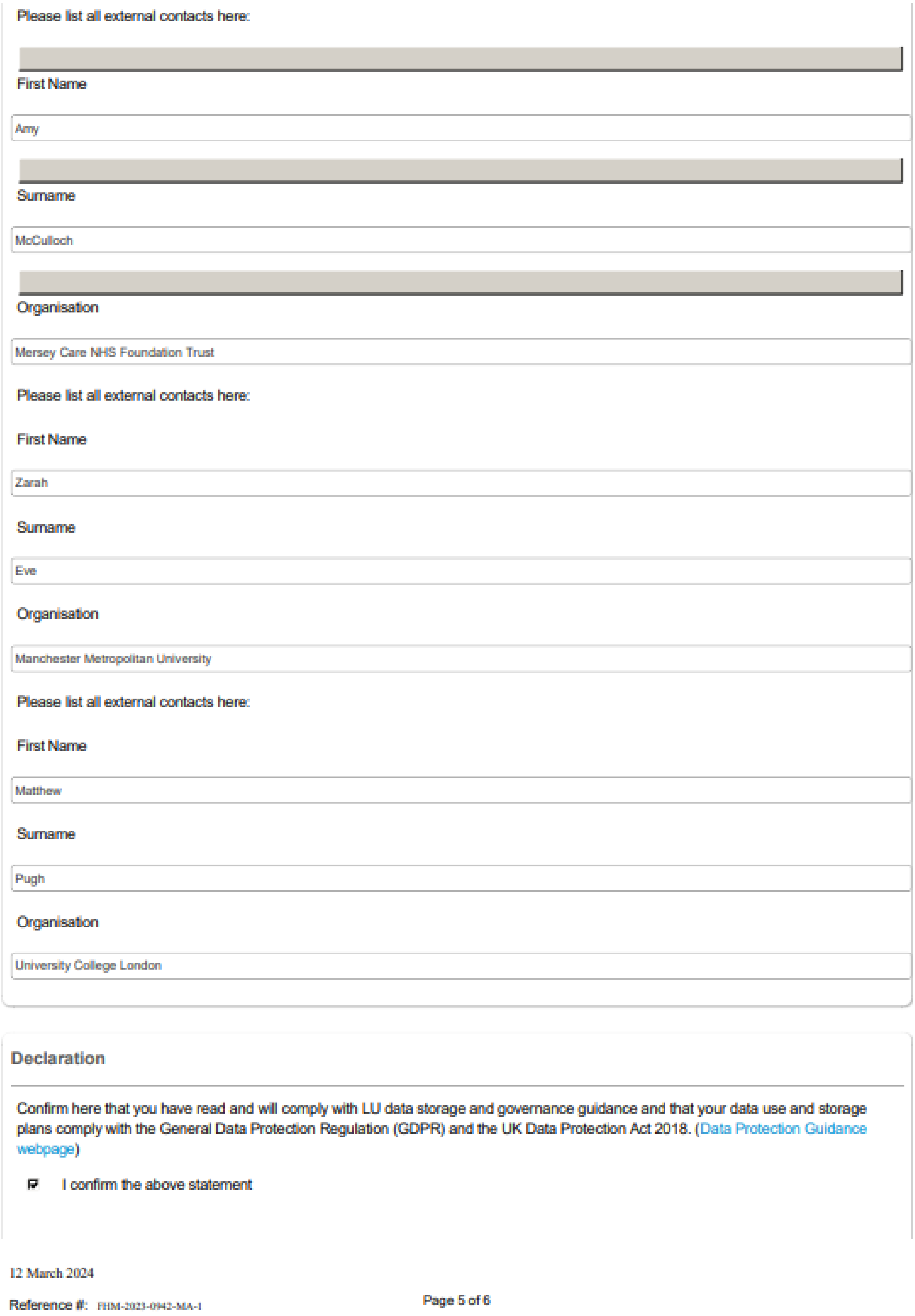
Notice:

Please note that adding students is not considered a minor amendment and should be added via a substantial amendment form.

12 March 2024

Reference #: FHM-2023-0942-MA-1

Page 4 of 6



Please list all external contacts here:

First Name

Amy

Surname

McCulloch

Organisation

Mersey Care NHS Foundation Trust

Please list all external contacts here:

First Name

Zarah

Surname

Eve

Organisation

Manchester Metropolitan University

Please list all external contacts here:

First Name

Matthew

Surname

Pugh

Organisation

University College London

## Declaration

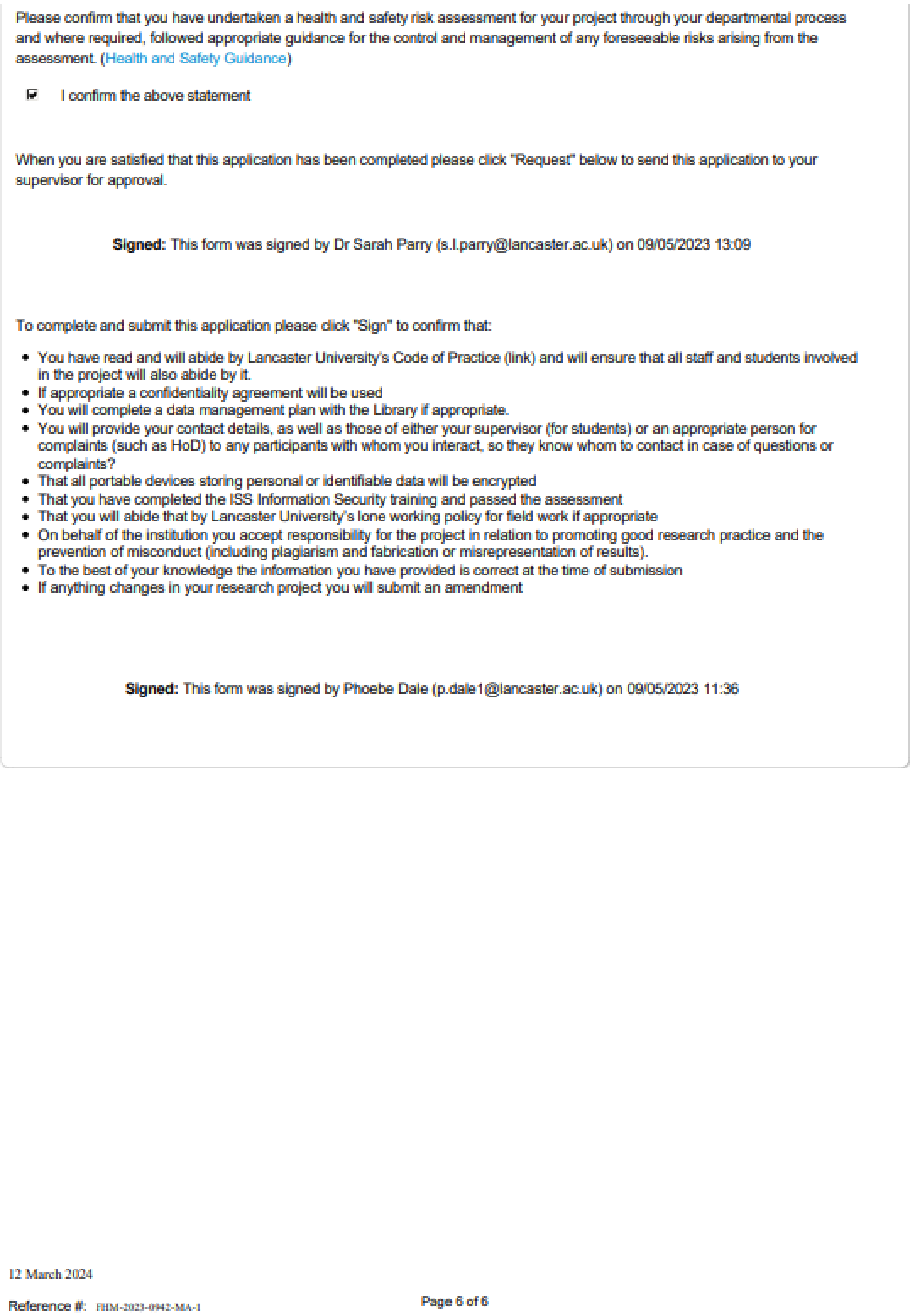
Confirm here that you have read and will comply with LU data storage and governance guidance and that your data use and storage plans comply with the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. (Data Protection Guidance webpage)

☑ I confirm the above statement

12 March 2024

Reference #: FHM-2023-0942-MA-1

Page 5 of 6



Please confirm that you have undertaken a health and safety risk assessment for your project through your departmental process and where required, followed appropriate guidance for the control and management of any foreseeable risks arising from the assessment. (Health and Safety Guidance)

☑ I confirm the above statement

When you are satisfied that this application has been completed please click "Request" below to send this application to your supervisor for approval.

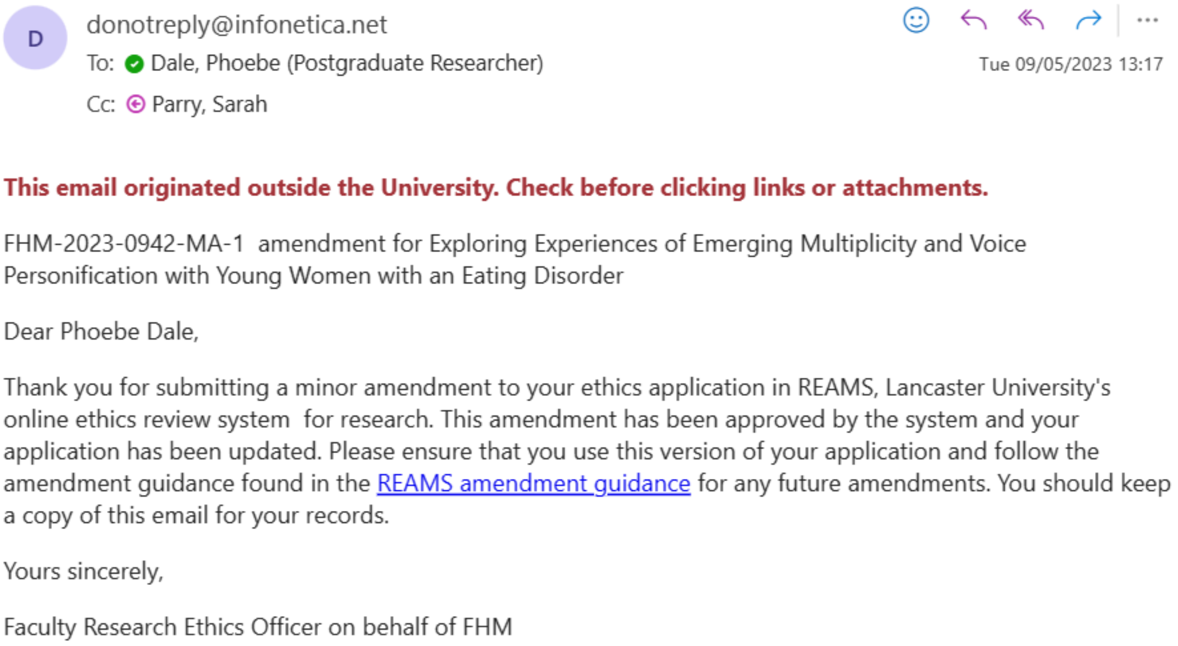
**Signed:** This form was signed by Dr Sarah Parry (s.l.parry@lancaster.ac.uk) on 09/05/2023 13:09

To complete and submit this application please click "Sign" to confirm that:

- You have read and will abide by Lancaster University's Code of Practice (link) and will ensure that all staff and students involved in the project will also abide by it.
- If appropriate a confidentiality agreement will be used
- You will complete a data management plan with the Library if appropriate.
- You will provide your contact details, as well as those of either your supervisor (for students) or an appropriate person for complaints (such as HoD) to any participants with whom you interact, so they know whom to contact in case of questions or complaints?
- That all portable devices storing personal or identifiable data will be encrypted
- That you have completed the ISS Information Security training and passed the assessment
- That you will abide that by Lancaster University's lone working policy for field work if appropriate
- On behalf of the institution you accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- To the best of your knowledge the information you have provided is correct at the time of submission
- If anything changes in your research project you will submit an amendment

**Signed:** This form was signed by Phoebe Dale (p.dale1@lancaster.ac.uk) on 09/05/2023 11:36

# Appendix 4-Q – Amendment Approval



donotreply@infonetica.net

To: Dale, Phoebe (Postgraduate Researcher)

Cc: Parry, Sarah

Tue 09/05/2023 13:17

**This email originated outside the University. Check before clicking links or attachments.**

FHM-2023-0942-MA-1 amendment for Exploring Experiences of Emerging Multiplicity and Voice Personification with Young Women with an Eating Disorder

Dear Phoebe Dale,

Thank you for submitting a minor amendment to your ethics application in REAMS, Lancaster University's online ethics review system for research. This amendment has been approved by the system and your application has been updated. Please ensure that you use this version of your application and follow the amendment guidance found in the REAMS amendment guidance for any future amendments. You should keep a copy of this email for your records.

Yours sincerely,

Faculty Research Ethics Officer on behalf of FHM