The internal eating disorder voice, childhood trauma, and eating psychopathology

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Overview

1. The eating disorder voice
2. Our research
3. Treatment implications
Voices across diagnoses

- Psychosis (Schnieder, 1959)
- Dissociative Identity Disorder (Bliss, 1980)
- Bipolar Affective Disorder (Toh et al., 2015)
- PTSD (McCarthy-Jones & Longden, 2015)
- Borderline Personality Disorder (Marrett et al., 2016)
- Major Depressive Disorder (Baethge et al., 2005)
- Obsession-Compulsive Disorder (Bortolon & Raffard, 2015)
Early descriptions of the EDV

The case of ‘Elsa’ (diagnosed with anorexia nervosa):

[Elsa states that].. “Sometimes I hear voices or feel things in my head, and sometimes I get frightening mental images”...

‘The voices seemed to be in conflict, some telling her “eat, eat, eat”, and others, “don’t, don’t, don’t”’ (p.11-12).

Bruch, 1978
What is the ‘eating disorder voice’?

« A second or third-person commentary on actions and consequences relating to eating, shape and weight »
Prevalence

- 33.3% (AN only) (Wentz et al., 2001)
- 94.5% (mixed ED sample) (Noordenbos et al., 2014)
- 96.2% (mixed ED sample) (Noordenbos et al., 2017)

Average = 74.6%
First-person references to the EDV

- Thin (2007) - Grace Bowman
- Monkey Taming (2006) - Judith Fathallah
- Slim to None (2003) - Jennifer Hendricks
- Purge (2009) - Nicole Johns
- Unbearable Lightness (2011) - Portia de Rossi
- Feeding the Hungry Heart (1993) - Geneen Roth
- The Cupcake Queen Bites Back (2013) – Jackie Tanner
- The Time in Between (2015) - Nancy Tucker
- An Apple a Day (2012) - Emma Woolf
Phenomenology

• Typically one voice (60%) but often two or more (40%)
• Usually internally generated yet separate to the ‘self’
  o Distinct from other forms of cognitions e.g. self-criticism
• Occasionaly described as externally generated and ‘alien’

See Noordenbos et al., 2014; Noordenbos, 2017; Rojo-Moreno et al., 2011
Living with the eating disorder voice

Overshadowed, BBC 3
"My head is screaming, “dirty, fat bitch, disgusting failure”…

"Loose weight you pathetic piece of crap” …

"You’re a failure, you’re fat, you’re ugly…”

It reminds me daily that I am undeserving, unloveable, worthless and pathetic…

"It would tell me, “they hate you and you can’t really trust them”…"

"I was never completely alone… [the voice] was my rock in hard times …

... People want to break the connection [with the voice]. They don’t realise I’d be lost with it…"

Hostile

Beguiling

... The voice was like my new life coach and I couldn’t think of any reason not to listen to it ….

... I knew at least I had A, and so things would be ok …

... It was easier to listen to the voice …

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Time-course & stages of change

1. Direction
   - Support
   - Assistance
   - Guidance

2. Domination
   - Abuse
   - Oppression
   - Isolation

3. Disempowerment
   - Obedience
   - Dependence
   - Erosion of the self

4. Disillusionment
   - Fighting
   - Resistance
   - Differentiation

5. Defiance
   - Grief
   - Loneliness
   - Susceptibility

6. Deliverance
   - Freedom
   - Independence
   - Reclamation

7. Disquiet

See Pugh & Waller, 2018
Understanding the EDV
Two issues...

• Many people who hear voices do not experience distress

• Not everyone who hears an EDV has an eating disorder
Cognitive model of AVHs

- Appraisals about voices generate distress:
  - Voice power (relative strength)
  - Malevolence (malicious intent)
  - Omnipotence (omniscience and authority)
  - Benevolence (benign intent)

*Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994*
And another issue...

- Where does the EDV come from?
Trauma-dissociation model of the EDV

High rates of childhood trauma in EDs
  e.g. Johnson et al., 2002
  e.g. Caslini et al., 2016

Dissociation pronounced in EDs
  e.g. Waller et al., 2003
  e.g. Farrington et al., 2002

High rates of voice-hearing in EDs
  e.g. Noordenbos et al., 2014

Childhood Trauma

Dissociation

Intrusive traumatic material

Childhood adversity produces intrusive traumatic material

Intrusive traumatic material experienced as decontextualised due to dissociation

Dissociated traumatic content experienced as ‘voice-like’ and alien to the self

See Longden et al., 2011;
Moskowitz & Corstens, 2007
Discussion

Literature suggests that the EDV:

- *Is a common experience across ED subtypes*
- *Plays a role in both eating pathology and recovery*
- *May be an area worthy of clinical intervention*

However, little is known about how the EDV:

- *Develops in EDs*
- *Interacts with core dimensions of eating pathology*
- *Is best conceptualised and treated*
Our Research
Participants

• Service-users attending Vincent Square EDS
• Study 1: Anorexia Nervosa (N = 63)
• Study 2: Anorexia Nervosa (N = 49)
• Study 3/4: Mixed Eating Disorder Sample (N = 85)
  • Anorexia Nervosa (N = 26) (31%)
  • Bulimia Nervosa (N = 29) (34%)
  • Eating Disorder ‘Unspecified’ (N = 22) (26%)
  • Binge-Eating Disorder (N = 8) (9%)
Measures

- Eating Disorder Examination Questionnaire (ED attitudes and behaviours)
- Body mass index (severity of weight loss)
- Voice Power Differential Scale, adapted (relative power)
- Beliefs about Voices Questionnaire Revised, adapted (benevolence, malevolence, omnipotence)
- Childhood Trauma Questionnaire (multiple forms of childhood abuse)
- Dissociative Experiences Scale II (global measure of dissociation)
(1) EDV and ED symptoms in AN

• EDV power predicts negative eating attitudes (EDE-Q global score)
  \( (t = 2.23; p < 0.04) \)

• EDV perceived as powerful and malevolence predicts lower body mass index
  \( (voice \ power: t = 2.24; p < 0.02) \)
  \( (voice \ malevolence: t = 2.96; p < 0.005) \)

See Pugh & Waller, 2016
(2) EDV and ED symptoms in mixed ED sample

- Negative eating attitudes (EDE-Q global) predicted by EDV:
  - Power (t = 2.06; p = 0.5)
  - Benevolence (t = 2.60; p = 0.2)
  - Omnipotence (t = 2.06; p = 0.5)

- No link between EDV appraisals and BMI or length of illness

See Pugh & Waller 2018, in prep.
(3) EDV Clusters in AN

<table>
<thead>
<tr>
<th>Illness variables</th>
<th>Weaker voice</th>
<th>Stronger voice</th>
<th>T-tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>M 25.8 (6.47)</td>
<td>M 29.3 (12.4)</td>
<td>t 1.10</td>
</tr>
<tr>
<td>Duration (m)</td>
<td>66.9 (59.3)</td>
<td>109.5 (89.7)</td>
<td>P .04</td>
</tr>
<tr>
<td>BMI</td>
<td>16.2 (1.34)</td>
<td>15.6 (1.63)</td>
<td>NS</td>
</tr>
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</table>

See Pugh & Waller, 2017

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(3) EDV Clusters in AN

<table>
<thead>
<tr>
<th>EDE-Q scales</th>
<th>Weaker voice</th>
<th>Stronger voice</th>
<th>T-tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global</td>
<td>3.09 (1.12)</td>
<td>4.44 (1.00)</td>
<td>4.32</td>
</tr>
<tr>
<td>Weight</td>
<td>2.97 (1.44)</td>
<td>4.54 (1.34)</td>
<td>3.84</td>
</tr>
<tr>
<td>Eating</td>
<td>2.88 (1.44)</td>
<td>3.83 (1.33)</td>
<td>2.33</td>
</tr>
<tr>
<td>Shape</td>
<td>3.70 (1.47)</td>
<td>5.14 (1.01)</td>
<td>3.66a</td>
</tr>
</tbody>
</table>
## (3) EDV Clusters in AN

<table>
<thead>
<tr>
<th>ED behaviours</th>
<th>Weaker voice</th>
<th>Stronger voice</th>
<th>T-tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binges</td>
<td>3.06 (5.75)</td>
<td>3.47 (6.32)</td>
<td>0.26 NS</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1.67 (6.14)</td>
<td>18.4 (47.5)</td>
<td>1.90a .04</td>
</tr>
<tr>
<td>Laxatives</td>
<td>0.00 -</td>
<td>5.43 (12.9)</td>
<td>2.30a .02</td>
</tr>
<tr>
<td>Over-exercise</td>
<td>2.56 (4.05)</td>
<td>12.2 (12.8)</td>
<td>3.81a .001</td>
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See Pugh & Waller, 2017
(4) EDV, trauma, and dissociation

- Childhood emotional abuse alone predicts EDV power
  \[(t = 2.77; p = 0.07)\]

- Dissociation partially mediates relationship between EDV power and childhood emotional abuse
- Significant reduction in effect shown earlier, showing mediation effect (sobel’s test – \[z = 2.09; p = .037\])

See Pugh & Waller, in prep
Discussion

- EDV influences aspects of eating pathology across diagnoses and so may play a maintaining role in eating disorders.
- Appraisals of the EDV (e.g. its perceived power) partly underlie this association.
- EDV experiences may partly stem from early emotional abuse (e.g. parental criticism) but are experienced as alien, perhaps due to dissociation.
- Cognitive models of voice hearing might apply to the EDV.
Limitations

• Does the EDV represent a ‘true’ hallucination, ‘pseudo’ hallucination, or inner speech (and does it matter?)

• Can we reliably differentiate the EDV from more established cognitions (e.g. overvalued beliefs or self-criticism)?

• Cross-sectional studies prevent inferences about causation
  • Need for longitudinal research
Treatment

Implications
What are the risks and benefits of working with the EDV?

<table>
<thead>
<tr>
<th>Potential risks</th>
<th>Potential benefits</th>
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<tbody>
<tr>
<td>Dismissal of experiences</td>
<td>Validation of lived experience</td>
</tr>
<tr>
<td>Denial of responsibility</td>
<td>Collaboration (against the voice)</td>
</tr>
<tr>
<td>Reification</td>
<td>Normalisation</td>
</tr>
<tr>
<td>Demonising self-parts</td>
<td>Enthusiasm</td>
</tr>
<tr>
<td>Destabilisation</td>
<td>Meaning-making</td>
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See Pudge, 2018; Pugh, 2016; Vitousek, 2005
A preliminary cognitive-behavioural protocol for working with the EDV
1. Build motivation

• Pros / cons of living in accordance with the voice
• Values clarification and comparison
• Expressive writing
  • ‘Friend’ and ‘Foe’ letters
  • ‘Letters from the future’
2. Formulation

- Voice diary keeping (symptom-voice links)
- Imagery for assessment (developmental origins)
- Voice dialogue (chairwork) (voice functions and intent)
  - Where do you come from?
  - What is your role in this individual's life?
  - What concerns you about not performing this role?
3. Managing voice-related distress

Important during the early stages of working the EDV (e.g. schoolyard bully analogy)

- Mindfulness
- Self-soothing
- Two-chair techniques
  - E.g. two-chair self-soothing
4. Addressing benevolence

- Cost-benefits analysis
- Evidence for and against benevolent intent
- Thought experiments: *Would want your child to have an EDV?*
- Analogies (e.g. Mafia ‘shake-downs’)

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5. Addressing power imbalances

• Cognitive techniques
  • Cost-benefits analysis
  • Evidence for and against relative voice power
• Behavioural experiments to test EDV power and omniscience
  • EDV predictions vs. ‘Healthy’ predictions
• Healthy counter-responding
  • Developing counter-responding (e.g. chairwork role-plays)
  • Reinforcing counter-responses (e.g. audio flashcards)
6. Addressing Traumatic Origins

- Imagery rescripting
- Empty-chair techniques
7. Other issues

• Building a healthy internal voice (e.g. compassionate mind techs)
• Addressing core beliefs which manifest as the EDV
• Building external relationships (‘looking outwards’)
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• Staff and service-users at Vincent Square EDS
References

• Pugh, M. (2016). The internal ‘anorexic voice’: A feature or fallacy of eating disorders? *Advances in Eating Disorders*, 4,


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