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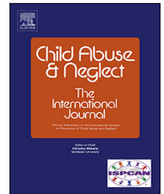
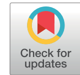


Childhood trauma, dissociation, and the internal eating disorder 'voice'



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ABSTRACT

Many individuals diagnosed with eating disorders describe their disorder as being represented by an internal 'voice'. In line with cognitive models of voice-hearing, previous research has identified associations between voice appraisals and eating psychopathology in anorexia nervosa. Whether these findings generalise to other eating disorder subtypes remains unknown. The aetiology of the internal eating disorder voice also remains unclear. Traumatic-dissociative models of voice-hearing, which link such experiences to decontexualised material arising from early traumatic events, might also be relevant to eating disorder groups. To determine whether cognitive models of trauma and voice-hearing apply across eating disorder subtypes, 85 individuals fulfilling ICD-10 criteria for an eating disorder completed self-report measures regarding eating disorder cognitions, voice-related appraisals, childhood trauma, and dissociation. The relative power of the eating disorder voice was found to be positively associated with experiences of childhood emotional abuse, and this relationship was partly mediated by dissociation. In addition, eating disorder voices appraised as powerful and benevolent predicted more negative attitudes towards eating across diagnostic groups, but were unrelated to disordered eating behaviours or weight. These findings suggest that the eating disorder voice plays a meaningful role in eating pathology across diagnoses and that this experience might be related, in part, to experiences of childhood maltreatment. Therapeutic implications are discussed.

1. Introduction

Individuals with eating disorders (EDs) commonly refer to an internal 'voice' of their disorder, which has been defined as "a second or third person commentary on actions and consequences relating to eating, weight, and shape" (Pugh & Waller, 2016, pp. 622). Such experiences have been reported in some of the earliest psychotherapeutic descriptions of disordered eating (Bruch, 1978; Davis, 1991) and now represent a growing area for research. Incidence of the eating disorder voice (EDV) is estimated to range from 33.3% (anorexia nervosa [AN] alone) (Wentz, Gillberg, Gillberg, & Råstam, 2001) to 96.2% (mixed ED samples) (Noordenbos & van Geest, 2017). Regarding phenomenology, single EDVs are most often experienced by individuals, although two or more voices are not uncommon (Noordenbos, 2017). Typically, the EDV is experienced as internally generated (i.e., reflecting one's own thoughts and

Abbreviations: AN, anorexia nervosa; BMI, body mass index; BN, bulimia nervosa; CEA, childhood emotional abuse; ED, eating disorders; EDV, eating disorder voice; OSFED, Other Specified Feeding and Eating Disorders; TMD, trauma-dissociation model

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feelings towards shape, weight, and eating) and yet phenomenologically distinct from the self (Pugh, 2016). In a minority of cases, however, the EDV is described as having an external origin (e.g. Kelly, Kamali, & Brennan, 2004). Reflecting continuum models of voice-hearing (Baumeister, Sedgwick, Howes, & Peters, 2017; Bentall, 2003; Johns & van Os, 2001), these observations suggest that the EDV may exist at varying points between the poles of inner speech and 'true' auditory hallucinations.

Whilst the EDV has been referenced in many first-person accounts of EDs (e.g. Woolf, 2012), limited research has explored this phenomenon directly. Qualitative studies (Duncan, Sebar, & Lee, 2015; Higbed & Fox, 2010; Jenkins & Ogden, 2012; Tierney & Fox, 2010, 2011) suggest a stage-like progression in how the EDV is experienced and related to (Pugh, 2018). Many individuals describe the EDV as a positive presence in the early stages of illness and one which fulfils valued functions, such as providing comfort and guiding decision-making ('Direction'). With time, however, the EDV tends to adopt a more hostile, coercive and controlling persona ('Domination'), resulting in feelings of entrapment and subservience ('Disempowerment'). For some individuals, this may eventually galvanise resistance to the voice ('Defiance') and lead to a reclamation of autonomy and recovery ('Deliverance'). Unfortunately, changing one's relationship with the EDV may also carry costs such as feelings of loneliness and fears about relapse ('Disquiet'). Within this context, changes in how individuals relate to the EDV appears to mirror the transtheoretical stages of change (Prochaska, DiClemente, & Norcross, 1992) and shares some similarities with the temporal changes in voice-hearing and relating observed in other clinical groups (de Jager et al., 2016).

Quantitative studies also indicate that internal voices play a meaningful role in EDs. For example, the EDV has been associated with multiple clinical variables in AN including severity of weight loss, negative attitudes towards food, duration of illness, and the use of compensatory behaviours such as over-exercise (Pugh & Waller, 2016, 2017). In mixed ED groups, critical inner voices have been associated with poorer self-esteem and more dysfunctional attitudes towards shape, weight, and eating (Noordenbos, Aliakbari, & Campbell, 2014). Furthermore, individuals experiencing EDs tend to experience more frequent and distressing internal voices than non-clinical groups (Noordenbos & van Geest, 2017).

Whilst research suggests the EDV is related to disordered eating, the developmental origins of such experiences remain unclear. According to the trauma-dissociation model (TDM) of voice hearing (Longden, Madill, & Waterman, 2012; Moskowitz, Read, Farrelly, Rudegeair, & Williams, 2009), internal voices may represent decontextualized cognitive material arising from early traumatic events which intrude upon conscious awareness due to dissociative processes. In this way, internal voices can represent meaningful embodiments of traumatic events and early interpersonal-emotional conflicts (Corstens & Longden, 2013; Moskowitz & Corstens, 2008). In support of this model, a growing body of research indicates that dissociation is a reliable mediator in the relationship between childhood adversity and voice-hearing in psychosis (e.g., Cole, Newman-Taylor, & Kennedy, 2016; Perona-Garcelán et al., 2012; Varese, Barkus, & Bentall, 2012).

Research is yet to determine whether the TDM might generalise to voice-hearing in other groups, although its applicability to EDs does seem plausible. Previous studies have identified associations between eating psychopathology and multifarious forms of early trauma (e.g., Caslini et al., 2016). Historically, considerable attention has been paid to the role of childhood sexual abuse (CSA) and childhood physical abuse (CPA) in eating pathology, both of which represent risk factors for the development of EDs (Fullerton, Wonderlich, & Gosnell, 1995; Pope & Hudson, 1992; Welch & Fairburn, 1996). More recent studies have underscored the role of childhood emotional abuse (CEA) in EDs. CEA has been defined as "the sustained, repetitive, inappropriate emotional response to the child's experience of emption and its accompanying expressive behaviour" (O'Hagan, 1995, p. 456). CEA appears to be one of the most common forms of childhood abuse and potentially the most damaging (Kent & Waller, 2000 O'Hagan, 1993). Research indicates that CEA is particularly prevalent in the EDs (Grilo & Masheb, 2001; Kimber et al., 2017) and appears to be the form of abuse most clearly related to eating psychopathology (Fischer, Stojek, & Hartzell, 2010; Groleau et al., 2012; Kennedy, Ip, Samra, & Gorzalka, 2007; Kent & Waller, 2000). Whilst precise casual links between CEA and eating pathology remain unclear, cognitive-behavioural models of psychopathology suggest that early emotional abuse, particularly from caregivers, may lead to the development of negative core beliefs about the self, others, and the world, which in turn increase vulnerability to psychological disturbance in later life (via self-esteem), including disordered eating (Kent & Waller, 2000). Dissociation is also common across the EDs (Farrington et al., 2002; Van IJzendoorn & Schuengel, 1996) and has been shown to partly mediate the relationship between emotional abuse and eating pathology (Kent, Waller, & Dagnan, 1999; Kong & Bernstein, 2009).

A second issue for research relates to the causal mechanisms underlying the relationship between the EDV and eating psychopathology. According to the cognitive model of auditory hallucinations (Birchwood & Chadwick, 1997; Chadwick & Birchwood, 1994), voice-related distress is related to subjective appraisals of such events. For example, voices which are perceived as malevolent (i.e., with harmful intent) have been associated with elevated levels of depression and anxiety, whilst voices which are appraised as benevolent (i.e., with benign intent) tend to be engaged with (Chadwick & Birchwood, 1994). Regarding relative strength, voices which are perceived as being more powerful than the self are associated with both greater distress (Gilbert et al., 2001) and increased likelihood of acting upon commands (Birchwood et al., 2017). Preliminary research indicates that voice-related appraisals also interact with eating pathology in AN. For example, EDVs which are appraised as more powerful than the self are associated with more unhealthy attitudes towards shape, weight, and eating, whilst lower body mass index (BMI) is associated with voices which have the dual characteristics of being malevolent and powerful (Pugh & Waller, 2016). Whilst these results suggest that beliefs about voices influence eating psychopathology in AN, it is unclear whether they might generalise across other ED diagnostic subtypes.

This cross-sectional study aimed to establish whether cognitive and trauma-related models of voice-hearing (Birchwood & Chadwick, 1997; Longden et al., 2012) apply to experiences of the EDV across ED subtypes. The first hypothesis was that appraisals of the EDV would be related to transdiagnostic eating psychopathology. The second hypothesis was that there would be differences in EDV characteristics across ED diagnoses. The third and central hypothesis of this study was that the perceived power of the EDV would be positively associated with experiences of childhood abuse (namely, childhood emotional abuse), and that this association

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