Advocating Pluralistic Practice in Trauma Sensitive Obesity Care

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Submitted in fulfilment of the requirements of:

Doctor of Psychology (DPsych)

April 2021

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Acknowledgements and Dedication:

In loving memory of my Father LJB who passed away earlier this year.

My heartfelt gratitude to the individuals central to this portfolio and indeed to all who over the course of my training, have shared with me their stories, courage and trust and from whom it has been a privilege to learn.

To my brilliant research supervisor Dr Fran Smith, for your clarity, enthusiasm, and calming presence, thank you.

To my equally gifted clinical supervisors, Dr Caroline McArthur and Dr Russell Hurn, whom I quite simply would not have reached this point in my training without. For offering me placement and mentorship when I needed them most and for your wisdom, belief and encouragement, thank you. I hope that my future practice echoes the compassion, energy, skill and authenticity I have seen modelled in yours.

Thank you to the fabulous staff at [redacted] for welcoming me into a team that became an important part of my learning and for the laughter and tea shared in our far corner of the hospital, thank you. An extra thank you to Becka for her admin help, particularly during recruitment.

I cannot fully express my thanks to the people in my life who have continually supported me over the past year, the three years of my clinical training and the long four years before those. Of these, the three kindest and brightest people in my world; my husband, my son, and my daughter. For your love, your strength and your patience, thank you.

Declaration of Powers of Discretion

I hereby declare that the work presented in this portfolio is entirely my own, under the supervision of Dr. Fran Smith.

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Advocating Pluralistic Practice in Trauma Sensitive Obesity Care

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Compassionate Bite by Compassionate Bite.

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Preface

This portfolio emphasises the importance of sensitively making sense of experience; as a client, a counselling psychologist, and a research practitioner.

In both research and clinical components of our work as counselling psychologists, this includes contextualising experience in light of established and evolving psychological theory. Exploring experience through theory is essential to bringing coherence, structure and an evidence-basis to the work that assists us in supporting our clients to find their own understanding and way forward. However, our role also includes recognising the individuality of human experience and the unique combination of idiosyncrasies, vulnerability, energy, strength and fallibility we all hold.

I believe that our uniqueness is inevitably shaped by our inimitable social connectedness to the world, a connection that begins in utero and spans the lifetime. This personal and professional position evolved and grew throughout the development of the portfolio and the impact it has had on my professional practice. The criticality of understanding previous traumatic experiences and the importance of recognising the debilitating impact of chronic shame is highlighted by both the empirical research and the single case study. In turn, the importance of encouraging psychotherapeutic autonomy is emphasised. It is the prominent positioning and provision of client autonomy within pluralistic practice that draws me to the approach. My current therapeutic work tends to use the pluralistic frame to combine core relational elements of person-centred perspectives with practical applications from compassion-focused cognitive behavioural therapy. This way of working also reassures me that other evidence-based interventions can be included in the work according to how they might best suit an individual, family or group.

Together, the three pieces of work I present in the portfolio illustrate my belief that a pluralistic stance can provide a versatile and intuitive psychological approach within the landscape of counselling psychology and particularly in supporting people living with obesity who are seeking change.

i. Sections of the portfolio

Section A: Doctoral research thesis. My research thesis explores the phenomenon of frequent emotional eating in the context of living with severe obesity. A detailed interpretive phenomenological analysis of the lived experience of emotional eating described by people accessing support from a specialist NHS obesity and weight management service is presented. My initial review of existing literature on emotional eating revealed an area of study that spans disciplines and holds multiple academic conceptualisations. The research sought to uncover experiential reality and switch focus to how emotional eating is conceptualised by people for whom it is a regular experience.

Section B: Journal manuscript suitable for publication. Drawing from the thesis, I have chosen to write a paper suitable for submission to the peer-reviewed international journal *Clinical Obesity*. This publication is the official clinical journal of the World Obesity Federation published by John Wiley and Sons Ltd. The journal is listed with a two-year impact factor of 2.055 for 2019-20, a real-time impact factor of 4.8 in April 2021 and a CiteScore of 2.6 in 2019.

My impetus for selecting to write for this publication is its purportedly broad multidisciplinary readership. I have been struck from working at a weight management and obesity service by the extent to which, certainly at tier 3, obesity care is very much an interprofessional approach and benefits enormously from integrated and shared professional knowledge. Furthermore, increasing awareness and understanding of emotional eating among health care professionals transpired as important to participants, and several individuals implied this to be a significant part of their motivation for taking part in the study.

In particular, it emerged from the analysis that participants consider health care professionals to generally need an improved understanding of the personal significance that emotional eating can hold for people and that there can very often be important, longstanding and serious psychosocial underpinnings. These can include the ongoing impact of previous psychological traumas and emotional abuse; an aim of the article is, therefore, to raise awareness in the hope of encouraging trauma-

sensitive practice across multidisciplinary teams and perhaps encouraging psychological practitioners attached to specialist weight management services to seek where possible additional trauma-informed continued professional development trainings.

Seeking dissemination across healthcare disciplines has therefore felt an ethical responsibility of the study. The publishers of *clinical obesity* cite readership to include endocrinologists, cardiologists, gastroenterologists, nutritionists, dieticians, paediatricians, rheumatologists, bariatric surgeons, general surgeons, general practitioners, physiologists, epidemiologists, and specialist nurses. Psychologists, funding bodies and policymakers with interests in obesity are also cited as readers; and may find suggested implications for clinical practice and further research useful.

Author guidelines for publication are included after the manuscript. In keeping with other IPA studies previously published in the same journal, findings are exhibited in an abridged format, and illustrative quotes from participants transcripts are included in tabular form to maximise the inclusion of participant voice within word limitations. The overarching theme that emerged following analysis, 'a *deep-rooted* and *powerful* response to intense emotion', is enveloped in the article by presenting emotional eating as a response to intense affect, past trauma and chronic shame. My thesis details the full interpretive phenomenological analysis of the research and, true to the ontological position of interpretive phenomenological study and counselling psychology, explicitly includes my reflections and voice as researcher. As per the style of most pieces published in *clinical obesity*, including qualitative, I moved to writing in the third person. I hope that if published, the experiences courageously shared by the participants may inspire further work and provide a step in the direction of reducing stigma.

Section C: Professional component. The case study reports pluralistic therapeutic work with a young woman seeking support for her fear of trying new foods. My client and I were able to collaboratively formulate an understanding of why she avoids certain foods and finds trying new food overwhelmingly threatening. I discuss how a pluralistic way of working allowed the client to identify an individual goal and choose a therapeutic path forward. The pluralistic frame allowed the work to retain the person-

centred ethos that I consider core to counselling psychology whilst also drawing from compassion-focused therapy to help begin to reduce shame and traditional cognitive behavioural therapy, including introducing the client to new food through graded exposure. Tensions in the work, including navigation of how strategies from theoretically different orientations can be congruently utilised, are also discussed.

In thinking about the similarities between presentations of emotional eating and food neophobia, I also started to think about their dichotomy. The research study findings include the conceptualisation that emotional eating can be a potent means of avoiding feelings of intense distress; there is power found in eating. Conversely, for the client in the case study, power is essentially seated in 'not eating'; although, again, for the person experiencing it, the behaviour is perceived to avoid feelings of intense distress. In both situations, this experience of power, albeit bittersweet, stands in contrast to feelings of powerlessness that many people referred to feeling as children. In both types of presentation, current eating patterns contribute to preventing weight loss, which can maintain a reduction in quality of life arising from the physical ill health, daily practical challenges, and decreased psychological well-being often consequent to living with severe obesity.

ii. Themes of the portfolio

The juxtaposition of emotional eating and food-neo-phobia presented in my portfolio, wherein both eating and similarly food types not eaten are shown contributing to weight status, helps illustrate a point succinctly illuminated by one of the participants *"it's about so much more than food"*. These simple yet pertinent words in many ways epitomise a key message of the portfolio.

There are indeed many inter-relating factors that can intertwine with emotional eating, food neo-phobia and living with obesity. Those listed below are not an exhaustive list but highlight how many complex interlinking components can contribute to a person developing obesity and why I believe psychological intervention in obesity care should not be limited to a single modality. In addition to diet, other important determinants can include socioeconomic status, educational background, ethnicity, culture, inequality, family dynamics, attachment styles, childhood feeding patterns, loneliness and issues relating to identity, sexuality and gender. Similarly, physical and mental health status,

obesogenic medications, disability, learning disability, genetics, phenotype, neuroplasticity, and metabolism may also be involved. A person's identity can sometimes become bound to living with obesity, and as is highlighted by some of the participants in section A, both emotional eating and carrying excess weight can serve a protective function.

An individual's eating patterns and weight may also be impacted by significant life events, including pregnancies, bereavements, employment changes and other life transitions. As referred to throughout the portfolio, surviving trauma is, for some people, an important antecedent; moreover, it is sometimes only when looking to lose weight that these experiences and their impact are voiced. Past trauma may include single or complex presentations; physical, emotional, sexual abuse and neglect. Individuals may need a referral for specialist trauma-informed intervention and longer-term work. Others may need a space to tell their story, and some might at this point in their journey simply need us as professionals to acknowledge, believe and contain with a sensitivity that avoids perpetuating further shame.

Shame is a theme that interweaves throughout the portfolio. In the research study, it is presented as fuel for ongoing cycles of emotional eating, and in the case study necessitated a compassionate understanding to help the client make sense of her difficulties and allow graded exposure work to be approached in a way that felt safe. All three sections of the portfolio contend that reducing shame must be a priority of therapy and that working pluralistically can offer clients the autonomy that has sadly perhaps at other points in life been absent. In making sense of experiences and affording autonomy, therapeutic change can begin.

iii. Reflections on professional development

One of the findings of the research study highlights the misunderstanding people can encounter regarding emotional eating. It feels important to acknowledge my own lack of understanding of emotional eating and indeed living with obesity before beginning this work. On reflection, I had been acutely naïve. Until hearing the participants stories and reviewing existing literature, I had no comprehension that people may develop a relationship so powerful to food and eating that it may become akin to developmental attachment. Similarly, I had not considered how a person might live with obesity and

simultaneously suffer from malnutrition and vitamin deficiencies which can further impact physical and emotional well-being.

I wrote my initial research proposal one month before I began my placement at the service. At that stage, although I had an interest in working with clients with trauma presentations, I did not anticipate that issues pertaining to trauma, childhood experiences, attachment, or shame would be so central to the research. The participants and other people I have met who attend the service have taught me so much.

In chapter one of the thesis, I discuss language use and note how I have observed a welcome shift in the discourse used around living with obesity in published literature even since embarking on my initial literature review. I have begun to notice a similar shift within myself as I have become increasingly aware of how our language can inadvertently perpetuate shame and erect barriers. In reviewing earlier chapter drafts, my original research proposal and indeed IRAS application, I am struck by how my tone leant towards a more rigidly medicalised conceptualisation of obesity than I perhaps realised. Through the progression of the portfolio and my concurrent clinical training, I have gained an appreciation that finding understanding of our emotional, cognitive, behavioural and embodied experiences by locating them within the bio-medico-psychosocial contexts in which they occur or have occurred can bring empowerment and holistic healing.

Vicki Norton

April 2021

Section A. Doctoral Research Thesis

The Lived Experience of Emotional Eating:

An Interpretive Phenomenological Analysis among people attending a specialist NHS Weight Management and Obesity Service

Supervised by Dr Fran Smith

Abstract:

Many people occasionally emotionally eat in response to positive and negative affect independent of weight status. For individuals living with obesity, frequent emotional eating to regulate negative affect can impede sustained weight loss. Whilst research in the area has increased in recent years, further knowledge of the lived experiential process of emotional eating is needed. Similarly, understanding of how people conceptualise their emotional eating is sparse, particularly for those seeking specialist support from UK weight management and obesity services.

This study aimed to illuminate lived experience and situated understanding of the phenomenon as described by people accessing support from a tier-three NHS weight management service. Six participants, two men and four women, shared their idiographic experiences through an in-depth semi-structured interview. Following, Interpretive Phenomenological Analysis an overarching theme of "a 'deep-rooted' and 'powerful' response to intense emotions" emerged encapsulating four interlinked superordinate themes: (1) a spectrum of awareness of dynamic emotions, (2) the 'stuck' self is experienced within shame fuelled cycles (3) a compelling coping mechanism and (4) an entrenched and frequently misunderstood phenomenon.

Together with their associated subordinate themes, these findings are contextualised within key theory relating to conscious awareness, trauma, attachment, self-psychology, and addiction. Clinical implications are discussed and advocate using a pluralistic framework for offering person-centred holistic intervention for emotional eating with emotional underpinnings considered ahead of behavioural. Suggestions for further research are also made. The study has particularly emphasised the ongoing and cumulative impact of shame on the emotional eating cycle and recognises that previous trauma and emotional abuse are sometimes contributory factors that need sensitive acknowledgement.

Abbreviations List:

Acceptance and Commitment Therapy (ACT)
Adverse Childhood Experiences (ACE)
Anterior Cingulate (ACC)
Autonomic Nervous System (ANS)
Binge Eating Disorder (BED)
Body Mass Index (BMI)
Childhood Sexual Abuse (CSA)
Critical Narrative Analysis (CNA)
Dialectical Behaviour Therapy (DBT)
Emotional Eating/Emotionally Eat (EE)
Eye Movement Desensitisation and Reprocessing (EMDR).
Event-Related Potentials (ERPs)
Hypothalamo-Pituitary-Adrenal Axis (HPA)
Interpretive Phenomenological Analysis (IPA)
Internal Working Model (IWM)
Internalised Weight Bias (IWB)
Multi-disciplinary Team (MDT)
Patient Advice and Liaison Service (PALS)
Participant Information Sheet (PIS)
Research and Development (R&D)
The British Psychological Society (BPS)

Chapter 1: Literature Review

"all human beings everywhere are similarly constituted in their desire to love and be loved" - Montagu, 1956

1.1 Introduction

On occasion, many of us eat to regulate our emotions (Buckroyd & Rother, 2008). Indeed, emotional eating (EE) is reported by overweight, healthy, and underweight individuals (Frayn & Knäuper, 2018; Geliebter & Aversa, 2003). People are known to eat in response to both positive and negative emotional states (Bongers & Jansen, 2016; Evers et al., 2013, 2018) and associate different foods with different emotions (Buckroyd & Rother, 2008). EE is therefore known to exist both within and outside the context of obesity.

The attention of this current research is directed specifically towards EE among people living with severe obesity. In line with most literature on the topic, eating in response to *negative* emotional cues is focussed on in this review and research (Allison & Heshka, 1993; BPS, 2011; Haedt-Matt & Keel, 2011a; Macht, 2008). Throughout this chapter and thesis, I will argue that EE is a key phenomenon that needs further empirical exploration, especially given that an estimated 1.3 million individuals classified as obese use food for affect regulation (BPS, 2011).

This initial chapter intends to provide a critical review of key theory, literature and background information relevant to the current research. The chapter begins by providing a brief introduction to EE, the current 'obesity crises' and the cyclical nature of EE and obesity. Several biopsychosocial conceptualisations and theories have been suggested to 'explain' EE among people living with obesity. Section 2 presents some of these varied (albeit sometimes overlapping) ideas. In section 3, attention turns from research that attempts to *theoretically explain* to that which prioritises *describing the lived experience* of EE. Brief background information regarding current support for emotional eating and weight management is discussed in section 4. In section 5, I summarise my review of the literature and the salient gaps identified. The chapter concludes in section 6 with an introduction to the current study in light of this literature review.

Reflections on Language Use:

I have learnt throughout my training that counselling psychology is playing a vital role in carving out inclusive and holistic practice, and I believe that inclusivity can begin through careful construction of language.

In this thesis, I use the words 'obese' and 'obesity' in reference to people who experience being unhealthily overweight. This language mirrors that used by most participants (although it is important to note not all), definitions by the World Health Organisation (WHO) and authors of much of the literature included in this review.

However, I am very aware that for some, these terms are contentious and are, arguably, a relic of original conceptualisations of obesity rooted solely in a medical model. I hope this thesis will illustrate my belief that an integrated approach to weight management needs to be maintained moving forward and informed by biomedical-psychosocial, multi-professional and service-user understandings.

It has been refreshing to observe through reviewing the literature that a palpable shift has begun in how psychologists are shaping discourse in the field. It is particularly notable that documents outlining perspectives on obesity produced by the BPS differ significantly in the language used between 2011 and 2019, with the authors of the latter alerting readers to the first person and person-centred language now employed. I have hope that over time this change may begin to help shift the stigma that currently keeps the term obesity laden with contention.

I use the terms 'service-user', 'client' and 'patient' interchangeably throughout this thesis. I also, at times, prefer to simply say people.

1.1.1 Emotional Eating

Dalton (1997) argued that the term 'emotional eating' lacks precision. This vagueness likely stems from early theoretical models of obesity that assigned EE a 'peripheral role' (Arnow et al., 1995), despite initial arguments that for many, obesity results from "psychologically determined overeating" (Kaplan & Kaplan, 1957a, p. 181). The phenomenon has indeed been conceptualised in multiple and varied ways. Recent

meanings ascribed to EE include ‘a survival strategy’ (BPS, 2012), ‘eating in the absence of hunger’ (Arnow et al., 1995), a ‘behavioural profile’ (Wilfley et al., 2016), ‘affect phobia’ (Egan & Fox, 2017), ‘comfort eating’ (NHS, 2017), ‘a destructive eating habit’ (Abramson, 1993) and a means of ‘soothing’ (Beat, 2018).

Despite its ambiguity, EE has become frequently documented in the literature, and the use of the term has also increased colloquially in recent years. Mantau et al. (2018) emphasise EE’s significance and suggest that it sits among the causal factors of the current obesity epidemic. The association between EE and obesity is supported by research suggesting frequent EE is a predictor of increased body mass index (BMI) (Annesi, 2020b; Fox et al., 2017; Nolan et al., 2010) and frequent reports of EE perpetuating obesity (Robbins & Fray, 1980; van Strien et al., 2009). Stapleton and Mackay (2015) identified EE as the second strongest predictor of increased BMI after being aged fifty or over. However, it should be acknowledged that Stapleton and Mackay’s study had a gender bias, with 88.7% of 226 participants being female.

It is also important to note that using BMI as a health measurement is currently under debate (Rathbone, Jetten, et al., 2020). This contention is partly due to muscle mass forming part of the calculation, resulting in people with a muscular physique being erroneously categorised as overweight (NHS, 2020). Alternatively, neck and waist circumference are sometimes used clinically to measure fat tissue; however, this information is rarely provided in the literature (RCP, 2013).

Kaplan and Kaplan described “psychogenic” and “compulsive” eating that reduces anxiety arising from emotional conflict (1957a, p. 199). A tendency to consume more food than is ‘physiologically needed’ is sometimes described as characteristic of EE (Egan & Fox, 2017; Topham et al., 2011), and it can co-exist with binge eating disorder (BED) (Pinaquy et al., 2003). The type of food selected for EE is often described as highly palatable, sweet and energy-dense (Dallman et al., 2005; Mantau et al., 2018; van Strien et al., 2013).

1.1.2 Obesity

The World Health Organisation currently states:

“Overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health. A body mass index (BMI) over 25 is considered overweight, and over 30 is obese.”

(WHO, 2018)

This clinical definition provides a quantifiable means of calculating, classifying and ‘red-flagging’ the serious risk to mental and physical health obesity can bring. The statistics and information I present in this section testify how grave these risks are. Knowing a BMI is over 30 does not, however, tell us anything of how people subjectively experience life with obesity, nor how circumstance, mind and body have interacted as a person journeyed towards their current body weight.

At least 2.8 million people die each year globally from reasons relating to excess weight (WHO, 2020). Obesity can lead to a decrease in life expectancy by an average of nine years and can negatively affect mental health and reduce quality-adjusted life years (PHE, 2017). Living with obesity increases a person’s risk of developing type II diabetes, cardiovascular diseases, arthrosis, malnutrition, gallstones, liver disease, cancer and respiratory diseases, including a severe course of illness and increased morbidity if infected with COVID-19 (NHS, 2020; PHE, 2020a).

The rise and current acceleration of obesity is considered an epidemic (Abelson & Kennedy, 2004; RCP, 2013). In 2016 an estimated 1.9 billion adults worldwide were overweight, and of these, 650 million were categorised as living with obesity (WHO, 2018). Nearly 70% of men and almost 60% of women in 2018 were reported as overweight or living with obesity in England, with obesity rates among the highest in Europe (PHE, 2020b).

Sharp discrepancies exist in the prevalence of obesity. Figures published by Public Health England (PHE) suggest Black adults are most likely out of all ethnic groups to be living with overweight or obesity, and White British adults also have an increased likelihood, whereas adults from the Chinese ethnic group are least likely out of all ethnic groups to be unhealthily overweight (PHE, 2020c). People who have physical and learning disabilities and those living in deprived areas are also at increased risk

(PHE, 2019). Prevalence differs with age; 82% of men aged between 55 and 64 are considered overweight or living with obesity, and 70% of women between 65 and 74 (NHS, 2020). Children living in deprivation and poverty are over twice as likely to live with obesity as those in the least deprived areas (PHE, 2020b). The need for ongoing, cross-cultural and cross-discipline research into all aspects of obesity, including the emotional and behavioural, is clear.

Initially, obesity research focused mainly on causality and led to valuable biomedical understandings of obesity, including knowledge of genetic, physiological and metabolic factors (Buckroyd & Rother, 2008; Eapen et al., 2013; Yang et al., 2007). Subsequent application of this research has likewise tended to be biomedical. Unfortunately, obesity rates have continued to rise, and a research approach attending solely to causation branded reductionist (Thomas et al., 2008; Ueland et al., 2019). Over the past decade, qualitative studies have gradually begun to explore the interpersonal and existential dimensions of living with obesity (BPS, 2019; Ueland et al., 2019). However, many aspects of living with obesity remain qualitatively under-explored (Owen-Smith et al., 2014).

Obesity is a global concern and, as such, needs a multi-cultural understanding. McFerran and Mukhopadhyay (2013) provide an example of work that attempts to consider cultural validity. A series of quantitative studies explored ‘lay understandings’ of obesity among participants from five countries across three continents. These studies consistently showed that people who believe a lack of exercise causes obesity are more likely to be overweight. Drawing on goal-directed behaviour theories, McFerran and Mukhopadhyay argued that their findings demonstrate how beliefs surrounding obesity can determine eating behaviour. The overall argument purported that obesity “has an important, pervasive, and hitherto overlooked psychological antecedent” p.1428.

The above study focussed on beliefs and behaviour, however, the meanings we ascribe to food are arguably also driven by emotional experience (Buckroyd & Rother, 2008), and therefore research attention needs to consider embodied and emotional dimensions. Grant and Boersma (2005) provide an example of such work; their study used hermeneutic phenomenological analysis to explore eleven participants’ accounts

of their obesity. The analysis highlighted that many participants located their problematic relationship with food as starting in childhood; related to 'issues of control' and for some had become a coping strategy to 'numb' pain associated with childhood abuse and compensate for feelings of 'not belonging' (p. 212). In other words, the meaning participants ascribed to their obesity were both emotional and relational.

1.1.3 Cycles of Emotional Eating and Obesity

In addition to being a significant predictor of BMI, frequent EE over one year or more is associated with difficulty losing weight and poor weight control (Belcher, 2017; Blair et al., 1990). A bidirectional link across concepts of mood, food and obesity is suggested (Singh, 2014). This link is not to say that all people living with obesity engage in regular EE but recognises that for a subgroup of approximately 45% of people living with obesity, EE perpetuates and or precipitates their weight status (Buckroyd & Rother, 2008).

The maintenance of obesity through EE can be conceptualised as an ongoing cycle. Kaplan and Kaplan (1957b) described a cycle of 'anxiety and overeating' wherein eating rewards anxiety and reinforces more eating making it a difficult cycle to break because of the anxiety created by removing eating, which has become the primary mechanism for reducing anxiety. Grant & Boersma provide a succinct description of the cyclical nature of EE:

> "the cycle began with a negative emotional reaction-stress, loneliness or hurt-followed by eating, followed by feeling soothed, followed by guilt for having eaten, followed by self-loathing and so on" (2005, p. 216).

Interestingly, Grant and Boersma embed the 'emotional eating cycle' firmly aside social tensions. Owen-Smith et al. (2014) complement this emphasis on the social, describing social factors as fuelling ongoing "vicious cycles of emotional distress" and "downward spirals of weight gain" (p.1218). This conceptualisation (graphically presented in figure 1) is particularly helpful because it explicitly specifies stigma and discrimination as adverse social experiences within a cycle of emotional distress

contributing to the development of severe obesity (discussed further in section 1.2.8) and sampled participants accessing NHS weight management services.

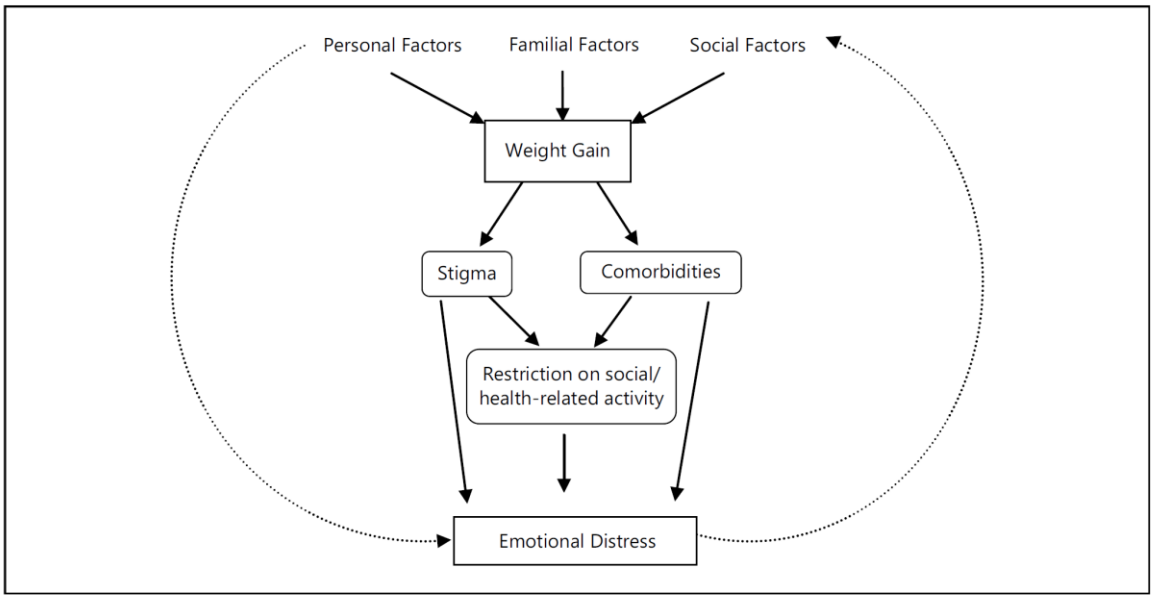

Figure 1.1: Conceptualisation of the relationship between emotional distress and weight gain (Owen-Smith et al., 2014, p. 1218)

Kaplan and Kaplan (1957b) postulated that EE becomes a habitual drive that any emotional conflict might activate. Habit formation involves initially conscious and goal-directed behaviours that, through repetition, become stimulus-driven and automatic (Everitt & Robbins, 2016; Smith & Graybiel, 2016).

Using a historical and cultural lens to contextualise participants' experiences of EE, Grant (2008) identified a theme entitled 'Solving the Problem Becomes the Problem…' with an associated sub-theme of 'autopilot'. Similarly, narrative work conducted by Christiansen et al. (2012) identified habitually experiencing a struggle between 'knowing and doing', automatically acting 'without knowing' and regularly experiencing eating as 'soothing' among people living with obesity which can contribute to the emotional eating cycle. These studies are examples of qualitative work that has helped highlight the cyclical pattern of EE. These studies demonstrate the value of the qualitative method for exploring nuanced experiences of EE that can result in clinically applicable 'bottom-up' understanding. Indeed, Grant (2008) reflected on how dialogue

between interviewers and participants is particularly conducive to exploring meanings surrounding EE.

1.2 Theories of Emotional Eating

1.2.1 Biological Understandings

Neuropsychological Correlates

Biological understandings begin from a position of typicality and look at individual physiological differences to account for eating behaviour changes (Mantau et al., 2018). The autonomic nervous system (ANS) is primed to respond to negative emotions, e.g. anger and fear (Carlson, 1916; Greeno & Wing, 1994; Schachter et al., 1968). Changes in autonomic arousal therein form a natural part of our 'flight or fight' response. Typically this results in reduced blood supply to the gastrointestinal tract to maximise blood flow to the brain and muscle tissues, increasing chances of survival under threat (Adam & Epel, 2007; Torres & Nowson, 2007). This process usually reduces appetite and decreases food intake when under stress (Schachter et al., 1968; Torres & Nowson, 2007; van Strien et al., 2013). However, the significant proportion of people living with obesity who frequently EE suggests that this biological process is not uniform or can be overridden (Buckroyd & Rother, 2008).

The hypothalamo-pituitary-adrenal axis (HPA) is involved in regulating the body's response to stress, emotions and mood. Animal studies have demonstrated that activity reduces across the HPA when high fat and high carbohydrate foods are consumed (Dallman et al., 2005; Macht, 1999; Macht, 2008; Schepers & Markus, 2015). This reduction in HPA activity decreases the stress response leading to a reduction in signs of stress and anxiety (Jauch-Chara & Oltmanns, 2014; Rangel, 2013); and is a likely component of the physiological mechanism for EE in humans (Dallman et al., 2005; Macht, 1999; Macht, 2008).

Blechert et al. (2014) measured Event-Related Potentials (ERPs) to identify brain responses in 'high-level' and 'low-level' style emotional eaters. Participants looked at pictures of highly calorific foods during induced emotionally negative states. 'High-level' emotional eaters reported increased food cravings whilst cravings for 'low-level'

emotional eaters decreased. Increased activity was noted in the parieto-occipital and right frontal brain regions of high-level emotional eaters only.

Reward centres located in the parahippocampal gyrus and anterior cingulate (ACC) show increased activation when people who regularly emotional eat anticipate eating a favoured food during a negative mood; greater activation in the pallidum, thalamus, and ACC is seen after eating, whereas non-emotional eaters showed decreased activation in these regions (Bohon et al., 2009).

Neurochemical Correlates

Neurotransmission of dopamine is recognised as key in regulating motivation to eat, stimulating appetitive and rewarding behaviours and likely mediates reward pathways (Davis et al.., 2012). It is hypothesised that dopamine produced in response to eating a favoured food when stressed activates these reward and pleasure centres in the brain (Davis et al., 2012; Dodds et al., 2012). It is suggested that with repeated EE, reward pathways develop that respond directly to that particular favoured food to the extent that bodily signals of satiety and hunger can be overridden (Singh, 2014). Subsequently, if these foods are available again at times of stress, their consumption increases (Dallman et al., 2005; Oliver & Wardle, 1999). This finding arguably provides a potential biological mechanism for the emotional eating cycle.

Research exploring neural plasticity and EE has been replicated in human and animal studies (Singh, 2014); however, evidence is mixed as to whether specific foods augment mood. Such ambiguity is particularly apparent regarding research into chocolate, which is consistently reported as craved and often purported as mood-enhancing (Hill & Heaton-Brown, 1994; Rogers & Smit, 2000). The characteristic sensual properties of chocolate may in part account for such cravings (Cartwright et al., 2007; Macht & Dettmer, 2006; Osman & Sobal, 2006), and the presence of psychoactive substances including theobromine, caffeine, phenylethylamine and anandamide are claimed to promote good mood (Osman & Sobal, 2006; Singh, 2014). However, there is argument that too few of these substances are present in chocolate to account for a substantial mood shift (Benton et al., 1998), and potential benefits are suggested to be at best ephemeral (Parker et al., 2006).

Work by Strahler and Nater (2018) also challenges assumptions that particular foods enhance mood. An ecological ambulatory assessment study was conducted that provided markers of neuroendocrine and autonomic activity. Participants rated mood and well-being, logged food and drink intake, and saliva samples were collected at four hourly intervals. These were tested to establish levels of cortisol, alpha-amylase and salivary flow rate. Whilst having a snack predicted lower fatigue, consuming high-fat foods were found detrimental to well-being. The study provides a rare example of neuropsychological research into EE conducted outside the laboratory.

Several other hormonal responses are thought to impact EE; e.g., increased progesterone and oestrogen levels during the menstrual cycle have been associated with increased EE (Klump et al., 2015; Leeners et al., 2017). Anger is known to facilitate the response between a psychosocial stressor and cortisol levels (Meye & Adan, 2013; Raspopow et al., 2014). Raised glucocorticoids and insulin are thought to consequently increase the drive for highly palatable foods and reduce the negative effects of stress in the anterior nucleus accumbens (Dallman et al., 2005).

After food is consumed, ghrelin levels decline in non-emotional eaters but remain in people who frequently emotionally eat, suggesting that for the latter, the remaining ghrelin allows eating to continue (Raspopow et al., 2014). Leptin hormones are associated with dopaminergic reward systems and are thought likely to be involved in maintaining EE behaviour (Cassioli et al., 2020). Typically leptin decreases appetitive drive once sufficient food has been eaten (Schepers & Markus, 2015). However, with increased glucocorticoid levels from stress, resistance can develop to the appetitive inhibitory effects of leptin; continued high leptin levels have been observed in people who report regular EE (Björntorp, 2001; Cassioli et al., 2020).

Genetics and Heritability

Over one hundred genes are currently associated with obesity, and EE may also have a genetic component (Rutters et al., 2009; Yang et al., 2007). Genotyping studies suggest that the dopamine D4 receptor acts as a ‘plasticity gene’ determining sensitivity to environmental stressors and has been associated with self-reports of EE (Barth et al., 2020; van Strien et al., 2015). However, Van Strien et al. (2015) only showed this finding in Caucasian females.

There is a suggestion that heritability influences the tendency to EE; however, studies have been relatively inconsistent with small effect sizes making causal claims difficult (Schepers & Markus, 2015; Singh, 2014). Furthermore, twin study findings have suggested that proclivity for EE arises more from environmental factors than heritability (Herle et al., 2018; van Jaarsveld et al., 2010).

Limitations of Biological Conceptualisations

Some theorists contend that knowledge of EE at neuronal and phenotype level remains poorly delineated (Blechert et al., 2014; Caroleo et al., 2018). There is also criticism that most studies have been laboratory-based and are low in ecological validity. Similarly, many biological studies of EE have been conducted only with animals limiting generalisability (Singh, 2014).

However, overall biological knowledge of EE is rapidly expanding and often complements other understandings, such as theories relating to the experience of trauma, addiction and emotional regulation.

1.2.2 Emotional Regulation

Emotional (or affect) regulation comprises intrinsic and extrinsic processes that monitor, evaluate, modify, and maintain the intensity and temporality of emotional responses (Thompson, 1994). Affect regulation models consider emotional regulation to arise from a learned response to emotional cues and grew from psychosomatic theories of obesity that consider EE a psychological defence (Egan & Fox, 2017; Haedt-Matt et al., 2014; Kaplan & Kaplan, 1957b).

Internal-External Theory

Schacter et al. (1968) put forward the ‘internal-external’ theory following an observation that eating when stressed typically decreases but for individuals living with obesity, it increases; this finding has since been repeatedly replicated (Adam & Epel, 2007; Oliver & Wardle, 1999). The internal-external theory proposes that decreased eating in healthy weight individuals occurs in response to internal physiological cues triggered by external stress (Herle et al., 2018; Schachter et al., 1968; van Strien &

Ouwens, 2003). However, for some people, a decrease in appetite does not occur as part of the stress response (Herman & Mack, 1975; Herman & Polivy, 1975; Schachter et al., 1968).

Schachter et al. (1968, 1971) suggested that as eating in response to stress becomes habitual, a dampening of interoceptive awareness occurs. This decreased awareness leads to confused internal arousal states, particularly so for cues regarding appetite and satiety and a subsequent over-reliance on external cues, including emotional states to prompt eating (Bruch, 1973; Kaplan, 1972; Schachter, 1971). Young et al. (2017) observed decreased metacognition and interoceptive prediction errors in people who report frequent EE, furthering the argument that difficulty with interoceptive awareness accounts for the self-regulation challenges that prompt EE. However, other commentators (e.g. Rodin, 1981) argue that whilst elegant, the internal-external theory creates a dichotomy that has become overemphasised and distracts from consideration of metabolic and behavioural interaction.

The term alexithymia was coined to describe emotional difficulties wherein a person finds it difficult to identify and articulate their feelings, has little imagination and a cognitive style predisposed towards the external (Bruch, 1962; Sifneos, 1973; Taylor et al., 1996). Studies have shown high traits of alexithymia in people who self-report regular EE, lending further support to internal-external theories of obesity and EE (Lyvers et al., 2019; Pinaquy et al., 2003; van Strien & Ouwens, 2007).

Affect Management Strategies

Affect management strategies can be 'antecedent focused' occurring before an emotional response fully develops and leading to physiological and psychological change, e.g. cognitive reappraisal, which allows thoughts to be positively shaped and a sense of 'distance' from the stressor experienced (Evers et al., 2010; Gross, 1998; Gross & John, 2003). Alternatively, 'response focused' strategies occur after the emotional response, e.g. 'expressive suppression', intending to reduce emotional expression (Ferrer et al., 2017; Gross & John, 2003; Lu et al., 2016).

Response focused strategies are generally considered maladaptive. EE is arguably a type of expressive suppression and can be conceptualised as a coping mechanism

responding to negative affect, i.e. stress, anxiety, low mood, anger, depression, loneliness etc. (Arnow et al., 1995; Dalton, 1997; Faith et al., 1997; Ferrer et al., 2017; Van Strien et al.,1986 and Zies, 2017). Like EE, addictions are usually considered maladaptive coping mechanisms; some theorists propose that food addictions can develop neurobiologically similar to substance and behavioural addictions (Cottone et al., 2019).

1.2.3 Addiction

Bychowski (1950) described an over-valuation and addiction to food that develops through early conditioned reflexes connecting the soothing of anxieties and frustrations to eating. Some contemporary theorists take a less definitive approach and avoid labelling eating behaviour as 'addictive', preferring to describe EE as '*resembling'* addictive behaviour (e.g. Bourdier et al., 2018, p. 536).

Although debate exists as to whether EE is an addiction per se, there is increasing positioning of food addiction associated with EE as a risk factor for obesity (Bourdier et al., 2018; Burmeister et al., 2013). A study of 1051 French university students (76.3% female) found participant scores for EE and scores on the modified Yale Food Addiction Scale (YFAS) were positively interrelated and correlated with self-reported levels of psychological distress and increased BMI (Bourdier et al., 2018).

Similarly, Benzerouk et al. (2018) conducted a cross-sectional study examining prevailing food addiction phenotype, psychiatric difficulties and maladaptive eating behaviour among bariatric surgery candidates. Of the 128 participants, 25% had a food addiction phenotype associated with a higher prevalence of affective disorders, alcohol use, EE and loss of control when consuming foods high in fat or sugar. Both studies show a positive interrelation between EE and food addiction. However, potential bias through self-report data is possible, and their generalisability is limited in terms of gender.

Neurobiological research implicating the brain's reward system also supports the construct of food addiction. Stress and highly palatable food have been shown to stimulate opioid release and decrease HPA axis activity, reducing the stress response

and overtime ‘reward dependence’ can develop (Adam & Epel, 2007). Research by Mancino et al. (2017) also supports that delta-opioid receptors are involved in arbitrating food-seeking behaviour reinforcement and demonstrated structural plasticity in the prefrontal cortex, hippocampus, and nucleus accumbens of mice trained through operant conditioning to acquire chocolate flavoured pellets. Gerhardt (2015) posits that emotional eaters find themselves needing to increase food consumption due to the closure of beta-endorphin receptors, similar to people dependent on alcohol reporting a need to increase alcohol consumption over time to attain the same effects.

Ziauddeen and Fletcher (2018) make an interesting albeit contentious point suggesting that conceptualising regular EE as an addiction provides an explanatory narrative to reduce stigma. Indeed, viewing ‘maladaptive’ eating behaviour through an addiction framework has been demonstrated to reduce stigma and blame (Latner et al., 2014).

There are similarities between EE and addiction e.g. impact on mood, external cue control of appetite, and reinforcement. However, there is an argument that food addiction is not pathologically addictive (Rogers & Smit, 2000; Wilson, 2010; Ziauddeen & Fletcher, 2018). Instead, some theorists argue that EE is better explained through the hedonic effects of reinforcing foods and psychological theories of restraint (Lowe & Butryn, 2007; Rogers & Smit, 2000; Volkow & Wise, 2005).

1.2.4 Restraint

High dietary restraint theory purports that chronic dieters who have recently restricted their food intake are more likely than ‘unrestrained eaters’ to overeat in response to negative affect (Herman & Mack, 1975; Herman, 1978; Herman & Polivy, 1980) or high cognitive load (Ward & Mann, 2000). High dietary restraint theory is supported by examples of people overeating whilst erroneously believing they had ‘broken’ their diet and diminishing their motivation to continue restrained dieting (Herman & Polivy, 1980; Sominsky & Spencer, 2014).

Restrained eating has been differentiated as a separate construct from EE by theorists who argue that EE is prompted by an 'ego threat stressor' and improves self-focused negative emotions (Heatherton et al., 1991). Other differentials include restrained eaters being more likely to eat in response to positive and negative emotions (Cools et al., 1992) and mood improvement with EE but not in restrained eaters (Macht & Mueller, 2008). The argument that restrained eating and EE are different constructs has gained further support from neurobiological studies demonstrating differentiated neural processes (see Volkow et al., 2003).

Although their mechanisms differ, restrained dieting is considered to increase the likelihood of EE (Herman & Polivy, 1980; Macht & Mueller, 2008; Van Strien et al., 1986). However, there is debate about whether EE is caused by or consequent to dietary restraint (Johnson et al., 2012; Polivy & Herman, 1985). Other ideas include the suggestion that chronic restrictive dieting can lead to difficulty distinguishing sensations of hunger and satiety, and therefore it is an interoceptive deficit that leads to eating rather than the most recent restraint (Herman & Polivy, 1980). Furthermore, a review of epidemiological and field study findings found little evidence that dietary restraint leads to disinhibited eating (Johnson et al., 2012).

There is also contention regarding the norms, reliability and construct validity of the psychometric 'restraint scale' devised by Herman et al. (1978), often used in studies investigating dietary restraint (Ruderman, 1983, 1985). Recent work looked at item responses on several inventories, including the restraint scale among healthy adults (n=510) and adults living with obesity (n=304); the restraint scale was found to show a 60% bias, whereas other questionnaires showed low to moderate item bias (Forbush et al., 2020). An alternative, three-factor model of eating behaviour, is proposed that considers the frequency of dieting and overeating (cycles of weight gain and weight loss), current dieting and weight suppression (sustained significant weight loss) (Lowe, 1993). Others suggest that restraint theory is valid in the specific circumstance of dieters who already tend to overeat (Ouwens et al., 2003; Stice & Shaw, 2018; Van Strien et al., 2000).

High dietary restraint theory concentrates on present-day cognitions leading to EE. In contrast, the next section discusses EE through the lens of attachment theory and therefore positions conceptualisations of EE in an individual's past.

1.2.5 Attachment

Attachment theory considers relational experiences in infancy and childhood (most significantly bonding with caregivers) to considerably impact our future interpersonal relationships, reflective functioning, affect regulation, self-esteem, and mental health (Friedman & Friedman, 2013; Lemma, 2015; Tasca & Balfour, 2014).

Characteristic styles of 'secure' and 'insecure' attachment have been identified. A person with a 'securely attached' style has experienced significant people as available to them when needed and therefore feels confident that they can tolerate distress (Mikulincer & Florian, 1995). Individuals who are securely attached can reflect perceptively on their experiences and relationships, communicate well, engage in metacognition and mentalisation, articulate needs and have a strong 'secure base' (Bevington, 2017; Bowlby, 1973; Goldberg et al., 2013; Johnson & Whiffen, 2003). People who have secure attachment styles can hold positive representations of themselves and others (Bevington, 2017; Johnson & Whiffen, 2003). For those with insecure attachment styles, this may be more problematic and can contribute to marked reactivity regarding potential or perceived loss and abandonment, difficulty trusting others, decreased distress tolerance and hyper-responsive activity in the amygdalae resulting in difficulty with affect management (Fearon et al., 2010; Riem et al., 2012; Sandoval-Carrillo et al., 2020; Schore, 2001; Zimmermann, 1999).

A review of over fifty studies has demonstrated that people struggling with 'disordered eating' are likely to have insecure attachment styles and disorganised mental states mediated by perfectionism and affect regulation difficulties (Tasca & Balfour, 2014). Insecure attachment has also been associated with increased BMI through disordered eating (Maras et al., 2016). Insecure attachment can be further differentiated into 'avoidant', 'anxious-ambivalent' and 'disorganised' types (Ainsworth, 1985; Ainsworth, 1978) and 'disorganised' (Hesse & Main, 2000; Main & Solomon, 1986, 1990). A person in an 'avoidant attachment' pattern is thought likely to have had negative responses to their care-seeking behaviour early in life, leading to an expectation of adverse outcomes if they express their emotions (Ainsworth, 1978). This expectation can result in individuals avoiding situations that may cause negative affect, inhibition of emotional display, avoidance of particular memories and a favouring of self-

sufficiency (Friedman & Friedman, 2013; Bowlby, 1995; Fraley & Hudson, 2017; Mikulincer & Florian, 1995).

In contrast, when someone is in an 'anxious-ambivalent' style of attachment, negative affect may be experienced in an exaggerated and hypervigilant way (Kobak et al., 2015; Mikulincer et al., 1990; Mikulincer & Florian, 1995). Ambivalence towards seeking support from others can result in increased rumination, self-blame, 'wishful' thinking, generalised anxiety and pessimistic appraisal of situations (Faber et al., 2018; Mikulincer & Florian, 1995; Mikulincer & Shaver, 2005; Mikulincer & Orbach, 1995). People in an anxious-ambivalent attachment style are more likely than controls to have disordered eating (De Paoli et al., 2017).

Research suggests that individuals in a 'disorganised attachment' style are at significant risk of psychopathology connected with fright (Hesse & Main, 1999, 2000). A disorganised attachment style presents in childhood with behaviour disorientated to the attachment system's goals (Gillath et al., 2016). There is evidence that mothers and other significant caregivers of children showing a disorganised attachment style have suffered significant loss and trauma (Main & Hesse, 1990). The traumatic experience can lead to depressed, disassociated, frightened or threatening behaviour in the caregiver leading to unresolved trauma in a second-generation (Hesse & Main, 1999). However, there is criticism of Hesse and Main's conceptualisation of disorganised attachment and calls for clarification on how disorganised attachments and fear interrelate conceptually and empirically (Duschinsky, 2018).

Bowlby proposed that schemas relating to an individual's relationships and attachment patterns become part of an 'internal working model' (IWM) stretching across the lifetime (Bowlby, 1958, 1973, 1999). Subsequent studies indicate that IWMs are processed and stored in the right hemisphere implicit-procedural memory systems and can impact future attachments and relationships (Bowlby, 1995; Fraley & Hudson, 2017; Schore, 2001). People who have attachment anxiety are theorised to find engagement with negative internal states problematic and may misinterpret these internal states as hunger (Alexander & Siegel, 2013).

Empirical work on attachment theory has shown people who regularly emotionally eat have a greater deficiency on the insecurely attached subscale than non-emotional eaters (Celec, 1994). The sample size of Celec's study was small (n=39) and included

only Caucasian women; however, meta-analysis has since shown consistent findings across the literature that EE and insecure attachment styles are associated (e.g. Cruz et al., 2015; Faber et al., 2018).

Cross-sectional work using online questionnaires in the USA and UK (n=1213) identified a perception among people who show attachment anxiety that they are less capable of disengaging from the negative emotions that lead to self-soothing through EE (Wilkinson et al., 2018). An online survey (n=117) used the three-factor eating questionnaire to measure eating styles; multiple regression analysis found attachment anxiety but not avoidant attachment styles to predict higher levels of uncontrolled and EE (Belcher, 2017). Another online questionnaire suggested maternal attachment anxiety and maternal 'emotional feeding' increase their child's likelihood of frequently engaging in EE (Hardman et al., 2016).

Among bariatric surgery candidates, an association between insecure attachment styles and EE has also been found, together with overall affect regulation difficulties (Taube-Schiff et al., 2015). Insecure attachments have been suggested as mediators for subsequent difficulty maintaining weight loss post-surgery (Magee-Burford, 2020). Overall, existing literature in this area implies that insecure attachment styles are often associated with developing and maintaining EE to manage affect.

Theory centred around attachment and EE closely interrelate with theories of self-concept and study of childhood trauma, as discussed in the next two sections.

1.2.6 Self Concept, Avoidance and Escape

Whilst positions on the precise utility and definition of self-concept vary, ideas relating to the 'self' provide a framework for understanding psychological disturbance and are of key theoretical and clinical value to psychologists (Bhar & Kyrios, 2016; Brinthaupt & Lipka, 1992; Kyrios, 2016). Constructs relating to self-concept occur across modalities, e.g. Rogerian personality theory considers self-concept to encapsulate our organised consistent perceptions and beliefs about ourselves, with therapy seeking to improve self-concept (Rogers, 1961); psychodynamic theories of 'true self, false self' (Winnicott, 1939) and schemas in the cognitive approach (Young, 1990).

Eating disorders and obesity have been conceptualised as ‘self-disorders’ (Blaine, 2009; Bruch, 1973; Mustillo et al., 2012; Skårderud, 2009). Experiences relating to losses, limitations and psychosocial pressures have been identified as leading to change in self-concept and development of self-hatred in people living with obesity (Sadati et al., 2016). Other studies have linked disturbance in self-concept and obesity mediated by childhood emotional abuse (Hymowitz et al., 2017), peer victimisation (Bacchini et al., 2017) and societal anti-obesity messages (Shentow-Bewsh et al., 2016).

Dixon & Baumeister (1991) postulated that when events occur unfavourable to our self-concept, we seek to avoid self-awareness. This experiential avoidance involves deliberately finding a means of avoiding or escaping the challenging private experiences associated with ‘the self’ (Dixon & Baumeister, 1991; Hayes et al., 1996). Through avoidance, an individual changes their cognitive response by narrowing the focus from internal distress and fixing instead on external stimuli, e.g. drinking alcohol (Hull et al., 1983; Steele & Josephs, 1988), smoking (Duval & Wicklund, 1972) and binge or otherwise disinhibited eating (Heatherton et al., 2016).

Theorists have argued that EE can be considered a form of avoidant distraction (Cowdrey & Park, 2012; Litwin et al., 2017; Spoor et al., 2007; Young & Limbers, 2017). Heatherton et al. (1991) proposed that during EE, a person is motivated to ‘escape the self’, usually following an ‘ego threat’ that makes self-awareness seem intolerable. Whilst eating, a purported attentional shift occurs away from the ego threat onto food; this results in “low levels of thinking or awareness […] with dis-attention to the long-term consequences” (Heatherton et al., 1991, p. 142).

Later work by Heatherton et al. (1998) further supported the notion that a desire to escape negative associations with ‘the self’ mediates emotional regulation difficulty that can increase eating. Food intake was recorded among female dieters and non-dieters (aged 16-31years) following self-relevant and non-self-relevant mood induction procedures, including task failure, music, suggestion, and imagined personal situations. Only self-associated mood states led to negative affect and consequently increased eating.

Spoor et al. (2007) sought to consider whether coping style mediates EE and negative affect. Their work established that emotion-oriented coping styles and avoidant distraction are positively associated with EE in healthy women and women struggling with disordered eating. A positively associated impact from negative affect was observed and accounted for by avoidant distraction. Litwin et al. (2017) studied a sample comprising 132 women (17.% African-American, 59.8% White-American) who completed mood, experiential avoidance, and EE measures. The results supported the findings of Spoor et al. (2007) and confirmed the hypothesis that experiential avoidance can mediate the relationship between negative emotions and EE. The authors argued the finding indicates interventions that target experiential avoidance, such as acceptance and commitment therapy (ACT) or dialectical behaviour therapy (DBT), may be therapeutically beneficial for reducing frequent EE.

Studies looking at avoidance and escape present strong arguments suggesting that EE facilitates avoidance of negative internal experiences and provides a diversion from threats to the self (Heatherton & Baumeister, 1991; Karekla & Panayiotou, 2011). However, work in this area has tended to include all female, mainly Caucasian and often undergraduate samples, and therefore external validity is limited. Most studies have been quantitative and include questionnaire measures which, while providing nomothetic support regarding associations between avoidance, escape, and EE, will not have been able to probe intricate aspects of avoidant experience, sensitivities surrounding self-awareness or constructions and deconstructions of self-concept. Further qualitative work looking at EE experiences may expand understanding of avoidance and escape from the self.

1.2.7 Trauma

Studies have frequently established associations between living with obesity and past traumatic experience (see D'Argenio et al., 2009; Felitti, 1993; King et al., 1996; Palmisano et al., 2016; Rohde et al., 2008). It is estimated that half of adults attending specialist obesity services have experienced adversity in childhood (BPS, 2019), and experience of childhood trauma is associated with an increased risk for frequent EE (Michopoulos et al., 2015).

Chronic maltreatment in childhood can lead to brain structure changes that increase sensitivity to the 'flight-fight-freeze' stress response and increased emotional dysregulation (Anda et al., 2006; Sominsky & Spencer, 2014; Thompson et al., 2014). Consequently, changed neurobiological pathways can have a significant long-term impact on multiple body systems (Wiss & Brewerton, 2020). Research has begun to consider that symptoms of dissociation in addition to emotional dysregulation may mediate the relationship between past trauma and disordered eating (Lyubomirsky et al., 2001; Moulton et al., 2015; Palmisano et al., 2018a) or that dissociation is in itself a form of self-regulation (Fox & Power, 2009).

The epidemiologic Adverse Childhood Experiences (ACE) study (n=9508) examined the breadth of childhood exposure to emotional, physical or sexual abuse and household dysfunction with later health, wellbeing, and risk behaviours (Felitti et al., 1998). The project grew from Dr Vincent Felitti's observation of high patient 'dropout' rates at his clinic for people living with obesity despite achieving significant weight loss (Stevens, 2012). Participants completed questionnaires probing seven adversity categories: psychological, physical, or sexual abuse; violence against their mother; living with people abusing substances, mentally ill or suicidal, or who had been to prison. The study revealed ACEs to be common, showed categories of adversity to interrelate and demonstrated exposure to multiple adversities showed a graded relationship to increased health difficulties and risk for leading causes of death in adulthood. Participants who had experienced four or more ACE categories showed a 1.4 to 1.6 fold increase in physical inactivity and severe obesity (Felitti et al., 1998).

Elevated ACE questionnaire scores have since been used to predict obesity in adulthood, as evidenced in a recent systematic review and meta-analysis of 18 qualitative and 10 quantitative studies (Wiss & Brewerton, 2020). The review identified a positive association between elevated ACE score and adult obesity (n=118,691) and found multiple exposures to ACEs predicted a 46% increase in the odds of living with obesity as an adult (Wiss & Brewerton, 2020). Qualitative findings cited social disruption, health behaviours and chronic stress associated with high ACE scores and obesity.

Some commentators have raised concerns that judgement or interpretation of experiences many years later introduces recall bias into ACE studies (Hardt & Rutter, 2004). However, da Silva and da Costa Maia (2013) showed stability in ACE accounts given at three different and significantly distant points in time and argue that false positives in retrospective studies of childhood abuse are considered rare. Current research on ACEs has looked to broaden and update the list of adverse experiences probed, e.g. adding categories including peer victimisation and rejection (Finkelhor et al., 2013) and death of a parent, close family member or a close friend (Javier et al., 2019).

Emotional Eating and Trauma

Research has established an association between childhood adversity and EE (Evers et al., 2010; Felitti, 1993; Michopoulos et al., 2015; Strodl & Wylie, 2020), and similarly a positive relationship between PTSD (particularly avoidance and dissociative 'numbing' symptoms) and EE (Kurland, 2019).

Felitti also worked on a case-control study, interviewing 100 patients living with obesity. Findings showed people struggling with obesity to have a higher prevalence of having suffered childhood sexual abuse, nonsexual childhood abuse, early parental loss and parental alcoholism (1993, p. 732). Many participants spoke of how obesity had become a "sexually protective device" and reported that they overate to cope with distressing emotions (Felitti, 1993, p. 732).

Michopoulos et al. (2015) investigated EE, emotional dysregulation, depression and PTSD among a sample of African-American participants with low socioeconomic status. Hierarchical linear regression suggested that childhood trauma, specifically emotional abuse, is associated with frequent EE in adulthood, mediated mostly by emotional dysregulation and, to a lesser extent, depression. The study had a large sample size of 1110, but the authors suggest it needs replication across demographics. The studies cross-sectional approach intrinsically prevents predictions of causality, and reliance on self-completed questionnaires introduces limits on validity. However, the overall findings support arguments that improving emotional regulation is a prudent therapeutic target for reducing EE in people presenting with a history of childhood adversity and particularly emotional abuse.

Strodl & Wylie (2020) conducted an online cross-sectional study involving 332 Australian participants who completed measurements on childhood trauma, eating behaviours and beliefs about emotion. A significant direct association was shown between suffering sexual abuse and later EE. Several indirect associations were also observed regarding beliefs about emotions being 'overwhelming', 'uncontrollable' and 'damaging'. While the authors advise cautious interpretation of the findings given small effect sizes, they argue the finding has potential clinical implications and suggest future research may establish whether an initial therapeutic targeting of emotions rather than behaviour might help people reduce EE. Causal analysis was not possible due to the cross-sectional design; the researchers also call for longitudinal research from a more representative sample (participants had mainly been Caucasian female undergraduates).

This bulk of evidence associating ACEs and experiencing EE and obesity in later life arguably suggest that symptoms of trauma need to be addressed before eating behaviours in order to help facilitate and sustain weight loss (Brewerton, 2007; Felitti et al., 2010; Mason et al., 2016; Wiss & Brewerton, 2020). However, research informing how best to offer trauma interventions in the context of EE and obesity is sparse and mixed. Tailored group or individual trauma-informed psychotherapy is considered beneficial, but availability is generally limited (McDonnell & Garbers, 2018). Mindfulness has been noted as beneficial for people who emotionally eat and have some PTSD symptoms but unhelpful if trauma symptoms are high (Kurland, 2019).

1.2.8 Psychosocial Understandings

Psychosocial Context and Relationships

Psychosocial factors have a complex bidirectional relationship with obesity (Calugi & Grave, 2020). In particular, the association between obesity and mental health difficulties, including depression, anxiety and disordered eating, is well established (Mannan et al., 2016; McCrea et al., 2012; Sockalingam & Hawa, 2018). Sometimes this is due in part to the prescribing of obesogenic medications (Berkowitz & Fabricatore, 2011; Gibson et al., 2011; Weiden, 2007) but can also involve social,

cognitive, behavioural and biological factors interacting in multiple and currently poorly understood ways (Sharma, 2012).

Other psychosocial factors predicting the risk of obesity include having low socioeconomic status (Caldwell & Sayer, 2019; Cook et al., 2017), concerns around body image (Sarwer et al., 2018; Thompson & Schaefer, 2018), limited social contact (de Wit et al., 2010; Jaremka & Pacanowski, 2019), low self-esteem (Coco et al., 2011; Denehy, 2002; Johnson, 2002), interpersonal sensitivity and internalised weight stigma (Calugi & Dalle Grave, 2020; Puhl & Heuer, 2009; Sogg et al., 2018, 2018).

Social context is known to be a particular determinant of food intake among people who are overweight and can differentially impact eating behaviour (Bevelander et al., 2012; Caldwell & Sayer, 2019; Salvy et al., 2007). Powell et al. (2015) conducted a scoping review of forty-five published papers; social contagion, social capital (wherein a sense of belonging can influence eating behaviour) and social selection (social connections being determined by weight) were identified as key interrelated processes through which social context can influence food choices and eating behaviour.

EE is included among the eating behaviours that social context can impact, and more work into social norms has been called for (Altheimer & Urry, 2019; Annesi et al., 2016; Puhl & Pearl, 2018). Annesi (2020a) illustrates the relevance of social context giving the example of a person experiencing social pressure to overeat when out for a meal with friends and later emotionally eating out of self-anger and frustration.

It is recognised that food, social expectations, embodied experience and social interaction are interlinked and hold importance across cultures, race, gender, religious and spiritual practices and rituals (Bevelander et al., 2012; Lupton, 2018; Mechefske, 2017). Given the myriad of social meaning embedded in constructions of food, eating, and mealtimes combined with the often purported role food holds in navigating and negotiating relationships, it is perhaps not surprising that social anxiety is also a predictor of increased EE (Efe et al., 2020; Etkin et al., 2016; Lazarevich et al., 2016; Ostrovsky et al., 2013).

Annesi et al. (2016) assessed psychosocial predictors of weight loss and controlled eating for predicting EE. Women were allocated randomly to either a group that received phone supported self-help (n=50) or in-person regular therapeutic contact (n=53). Improvements in psychosocial measures of mood, self-regulation, satisfaction and eating-related self-efficacy were significantly greater after six months in the personal contact group. Weight loss and decreased EE were significantly associated.

Similarly, Annesi (2020a) investigated the effects of EE intervention on long-term weight loss in community-based settings. Participants were allocated to a 'high interpersonal contact' therapeutic behavioural group (n=39) or a 'low interpersonal contact' psychoeducation group (n=36). Psychosocial factors were assessed throughout treatment with mood, EE, self-regulation, self-efficacy and weight documented. The group accessing high interpersonal contact and behavioural weight management methods showed significantly greater changes with weight loss of 6.5% and 6.8% at six and twenty-four months, respectively. The group accessing low interpersonal contact and psychoeducation showed 2.9% weight loss at six months and 1.8% at twenty-four months. EE reduction was significantly associated with weight loss throughout the study. The high interpersonal contact group also showed more of an increase in self-efficacy dimensions, self-regulation and reduction in symptoms of depression (Annesi, 2020a). Annesi states that this finding is particularly noteworthy because a significant bivariate relationship predicting EE changes based on altering mood through changed self-regulation is demonstrated. The work was conducted in the field, suggesting an implementable intervention for larger-scale community-based settings.

The two studies outlined above have limitations, including being all-female samples; 84-85% of participants were white and aged between their late thirties to forties, restricting generalisability. There is no information on the total amount of intervention time provided, feedback on group dynamics or measurements regarding exercise. Whilst the study has high external validity due to its' experimental field design, it has only limited internal validity and power. Future research is needed to clarify associations between variables. However, the studies illustrate that psychosocial factors, including mood, self-regulation, self-efficacy, and body image, are associated with EE. Moreover, women accessing more relational support showed the most

improvement, furthering evidence that interpersonal and social contexts can influence EE.

Food and early life

Perhaps, the most potent and ubiquitous symbolic representation of food is its synergy with notions of love and nurture. Montagu described a state of "nutritional interrelatedness" between mother and baby (1956, p. 69). It is from this early fusion psychosomatic theorists argue that eating becomes laden with the "emotional complexities of the interaction between mother and child" (Bruch, 1955, p. 68). Equally, this interaction emphasises that physiological and psychological experience is intertwined from early life, and as Bruch (1955) pointed out, from infancy onwards, eating and food become experienced as interpersonal interactions.

The nutrition of the growing foetus is completely dependent on the mother, and it is now understood that critical emotional development also begins in-utero, continues through the first two years of life, is much determined by the physical and emotional well-being of the mother and inexorably her social environment (Blakemore et al., 2013; Chamberlain, 1999; DiPietro, 2012; Glover, 1997). Research has indicated that responsiveness and ability to differentiate between vocal expressions of emotion is present neonatally and dependent on prenatal experience (Bolten et al., 2013; Mastropieri & Turkewitz, 1999). There is a suggestion that maternal exposure to chronic stress is linked to problematic later behavioural outcomes in their child (O'Donnell et al., 2009). A mechanism for this is thought to be chronic stress leading to HPA activation and increased maternal cortisol levels that may downregulate the hormone 11-βHSD2; allowing cortisol to cross the placenta and reach the developing foetus (Bolten et al., 2013; DiPietro, 2012). Maternal stress during pregnancy has also been linked to decreased volume of neonatal hippocampi and amygdalae (both functionally involved in emotion and appetitive processes) and increased secretion of leptin hormone, which moderates appetite (Michels et al., 2017).

It is indisputable that following birth, an infant continues to be dependent on caregivers to provide the nourishment needed for survival (Montagu, 1956; Parkin, 2006). Of course, there is a difference between 'surviving' and 'thriving', and social context is

vital to the latter. Gerhardt (2015) points out that even when a child's nutritional needs are fulfilled, and developmental milestones are met, their emotional development may be hampered if the home environment is not nurturing, as demonstrated by studies on attachment (see section 1.2.5).

Psychodynamic theorists place much emphasis on early feeding and bonding experiences. This emphasis is particularly overt in Kleinian thinking on object relations which postulate that a baby's first experiential awareness of 'good' and 'bad' is acquired through feeding (Lemma, 2015a). Klein (1946) suggested that our initial emotional experiencing begins through awareness of 'otherness', starts as polar and impacts our later psychic development. There are times when a baby feels soothed by an attentive mother whose 'good breast' provides satiety, comfort and pleasure but other times when the breast is empty, or the mother is unavailable, bringing the baby frustration, fear and a sense of deprivation (Klein, 1946). Extending Klein's work, Bion theorised that it is essential a baby has an emotionally responsive caregiver who 'contains' the resultant anxieties. Without such a figure, defences form to manage overwhelming emotion (Bion, 1962).

Winnicott emphasised the benefit of the infant-maternal bond that can form during nursing to the child's ongoing emotional development (Winnicott, 1939). While revering breastfeeding, Winnicott emphasised that where breastfeeding is problematic, the mother's well-being must be prioritised in order for her to be emotionally able to 'hold' and provide 'good enough' parenting for her child (Winnicott, 1953, 1973). A 'good enough' parent, according to Winnicott, can meet their child's developmental needs and afford them the chance to reach emotional maturity.

Family associations and attitudes towards food

Family relationships and attitudes towards each other and to food can impact a tendency to emotionally eat and contribute to the reinforcement of learned feeding behaviour (Berge et al., 2012; Fujiwara & Kodama, 1992; Ganley, 1992). Families considered 'dysfunctional' are associated with higher levels of EE among individual family members (Hasenboehler et al., 2009). Whilst care needs to be taken as to what constitutes 'dysfunction'; the finding is consistent with the 'family systems model' of obesity, which theorises EE and obesity are maintained through the regulatory

purpose served within the family's systemic functioning (Ganley, 1986, 1992). Although the family systems model is fascinating, societal shifts and constructs of the family have changed significantly over the past thirty years. Components of the theory perhaps need updating to ensure they are cross-culturally still relevant. For example, a US-based study did not find conflict between parents and adolescents increases the likelihood of EE (Darling et al., 2019). It is, however, evident throughout the literature that family attitudes can influence a child's later eating behaviour.

Parental feeding styles and 'emotional over-feeding'

Parental feeding style may also contribute to a tendency towards EE (Demir & Bektas, 2017). Several characteristics of parental feeding have been identified, including responsiveness (Carnell & Wardle, 2007b), parental authority (Baumrind, 1971; Hughes et al., 2005) and use of coercion (Ogden et al., 2006). Feeding style types include 'emotional feeding' where the parent moderates a child's mood through food, 'instrumental feeding' involving treats being offered as enticements to eat, controlling or restricting the child's dietary intake and prompting or pressurising increased food intake (Faith et al., 2004; Wardle, 2002; Wardle et al., 2001).

A child's innate capacity to self-regulate dietary intake may become conditioned to reduce in response to a particular parental feeding style (Birch & Fisher, 1998). Feeding that is mainly controlled can result in decreased awareness of internal satiety and hunger (Carper et al., 2000) and is predictive of a later propensity for EE, particularly in boys (van Strien & Bazelier, 2007). Having learnt to ignore or suppress their internal means of regulation, the child may become increasingly dependent on external cues, including emotions and discomfort to cue hunger and satiety (Carnell & Wardle, 2007a; van Strien & Bazelier, 2007; Wardle, 2002). A response pattern may then develop wherein any state of heightened arousal can prompt eating (Bruch, 1973).

Alongside its identification as a parental feeding style, 'emotional feeding,' wherein food is offered as an interpersonal source of empathic soothing and emotional regulation, is recognised across cultures (Hamburg et al., 2014). Research has linked parental emotional feeding with increased child and adolescent EE in cross-sectional, retrospective, and prospective studies (Christensen, 2019). Negative maternal affect

leading to EE that is modelled to a child in addition to emotionally feeding has been identified (Rodgers et al., 2014). Maternal attachment anxiety has also been associated with later EE by the child, arbitrated by disinhibited eating and emotional feeding (Hardman et al., 2016; Wilkinson et al., 2018).

Emotional expression in childhood and affect phobia

The extent to which a child can express emotion influences their recognition and response towards emotions as an adult (van Strien, 2018a). It is theorised that some adults may adopt strategies such as EE to cope with 'affect phobia' (Haslam et al., 2012; McCullough & Andrews, 2001). Affect phobia is, in essence, 'fear of feeling' (McCullough & Andrews, 2001). Theoretically stemming from a combination of psychodynamic and learning theory, affect phobia is argued to arise from negative childhood experiences of showing emotion and invalidating family environments that discouraged or ignored free emotional expression (Haslam et al., 2012). Over time it is suggested that a child learns that negative emotional states are considered unacceptable and so adopt defence mechanisms to block or reduce awareness of negative states (Haslam et al., 2012; Root & Fallon, 1989).

These may develop into beliefs that showing emotion is a sign of weakness that should be controlled; such beliefs have been associated with higher eating psychopathology in women (Meyer et al., 2010). EE is conceptualised as serving to defend against the fear of consciously experiencing and expressing negative emotion (Haslam et al., 2012; Meyer et al., 2010). Cross-sectional research with ninety-seven participants demonstrated that attitudes towards emotional expression are associated with an increase in EE and higher BMI, supporting the affect phobia model of EE (Fox et al., 2017). Similarly, the 'schematic propositional analogical associative representation system' model suggests that inhibited childhood expression of emotion can dissociate emotions from the self and encourage adoption of maladaptive eating behaviour to regulate emotion (Fox & Power, 2009).

Advertising

Throughout the 20th-century companies consistently drew on ideals of 'mother-love', nourishment and nurture discussed earlier in this section to advertise food which arguably furthered the power of food as a symbol of love. The most pervasive and

persuasive of advertising targeted women with the fundamental message that "food is love" (Parkin, 2006, p. 30). From Campbell's marketing of the "*emotional power of soup*" to commercials describing McDonald's as *"the glue that holds friends and families together"* commercials have repeatedly reinforced the notion that food supplies emotional comfort (Parkin, 2006, p. 36). Qualitative work has suggested that advertising can influence rumination over food, justify eating through hedonic rationalisation and incite cravings to emotionally eat (Kemp et al., 2011).

Stigma and Shame

The stigma surrounding obesity and derogatory discourses concerning the meaning of 'fat' is sadly pervasive (Lupton, 2018; Sarwer & Heinberg, 2020). People living with obesity are likely to face 'multiple forms' of prejudice based on their weight from many sectors of society (Jackson, 2016; Puhl & Heuer, 2009). Potential employers have been found to attribute poor leadership skills and predict limited future success to job applicants who are overweight and are less likely to hire or promote someone who is obese (Giel et al., 2012; Puhl & Pearl, 2018). Burmeister & Carels observe that obesity is "still considered 'fair game' for public joking and ridicule" (2014, p. 223), and 'comedy' scenes in film and television continue to regularly stereotype and mock characters who are overweight and portray 'comfort eating' as laughable.

Disconcertingly weight prejudice and discrimination among healthcare professionals is known to be rife across disciplines (Flint et al., 2017; Phelan et al., 2015; Rathbone, Cruwys, et al., 2020; Wu & Berry, 2018). Quality of care is compromised with less respect, consultation time, intervention, screening and investigations offered to people living with obesity (Bertakis & Azari, 2005; Bocquier et al., 2005; Mold & Forbes, 2013; Zestcott et al., 2016). Negatively held beliefs perpetuating this prejudice include ideas that people living with obesity are 'lazy', 'stupid', 'non-compliant' and 'lack willpower' (Brown, 2006; Huizinga et al., 2009; Poon & Tarrant, 2009). Disturbingly, researchers and specialists working in the field of obesity are included in expressing this prejudice (Jung et al., 2015; Tanneberger & Ciupitu-Plath, 2018; Tomiyama et al., 2015). The BPS has recently acknowledged this harmful and negligent practice and warns patients face:

> “inherent weight bias from those who have designed and who work within such services means that they can receive poor levels of care and experience greater physical and psychological adversity as a result…”.
>
> (BPS, 2019, p. 23).

Fear of judgement can lead individuals to avoid seeking medical care, both for issues relating to their obesity and other health conditions (Alberga et al., 2019; Flint et al., 2017; Puhl & Heuer, 2009; Wu & Berry, 2018). The problem has become such a barrier to patient care that weight stigma in itself has been identified as a psychosocial contributor to obesity, with calls for stigma to be addressed as a public health priority (Pearl et al., 2020). Increased feelings of shame, worthlessness and weight-self stigma can, in turn, precipitate and perpetuate mental health difficulties, including anxiety and depression and increase patterns of disordered eating (Sarwer & Heinberg, 2020; Vartanian & Porter, 2016). EE has consistently been shown to increase among people with obesity in response to feelings of stigmatisation (Farrow & Tarrant, 2009; O’Brien et al., 2013; O’Brien et al., 2016).

Internalised Weight Bias (IWB) describes attributing weight-related stereotypes to oneself resulting in self-stigmatisation and is suggested a potential mechanism for increased EE (Hayward et al., 2018; Lawson et al., 2020; Marshall et al., 2020). In a study of active-duty service members in the U.S. (n=119), nearly half reported increased EE in response to feelings of anxiety, depression and internalisation of weight bias resulting from stigmatisation (Schvey et al., 2017).

1.3 Lived Experience of Emotional Eating

Many of the studies included in this review are quantitative. However, the past decade has seen an increased output of qualitative research looking at the lived experience of living with obesity (e.g. Haga et al., 2020; Sadati et al., 2016; Randall-Arell & Utley, 2014). The focus of lived experience research among people living with obesity has begun to include experiences of EE.

Hernandez-Hons & Woolley (2012) explored lived experiences of prior and current attachment relationships, contextual influences and connections with food among people tending to emotionally eat. Eight women from South California who self-identified as 'emotional eaters' were recruited from the local community and are described as comprising a 'culturally diverse' sample. The phenomenological analysis identified relational and cultural factors connecting attachment-related issues with EE, including self-judgement, emotional hunger, past relationships, EE as reminiscent of ambivalent attachment, and EE's conceptualisations as an addiction to cope with insecure attachment.

Given existing research documenting the association between attachment types and EE (described in section 1.2.5), the decision to view the data through an 'attachment lens' is relevant and allows the findings to be considered from this important theoretical viewpoint. However, the researchers noted that a different theoretical lens might produce further findings. The research had aimed to be culturally diverse, which was achieved to an extent; however, the studies demographic did not diversify religious preference, academic achievements, sexual orientation and financial status.

Zies (2017) followed Moustakas's (1994) approach to phenomenological analysis to explore data collected from twelve semi-structured interviews. The study aimed to explore EE patterns in the context of working in the field of mental health. The theoretical framework underpinning the work drew from stress response theory (Selye, 1936) and the affect regulation model (Heatherton & Baumeister, 1991). Chronic stressors, including 'unrealistic job demands' and 'unpredictable work schedules', were identified as EE triggers. Participants reported often choosing fast food that could be eaten at desks and increased snacking resultant of stress or having skipped meals due to work pressures. The occupational rather than clinical stance of the study is interesting and identified stressors specific to the work environment. It would be helpful to know whether the participants struggle with their weight; however, not knowing this kept EE experiences foregrounded. The researchers cited limitations, including drawing from one place of work only and state the small sample size combined with financial and time constraints meant other theoretical understandings of EE, including restriction and escape theories, could not be discussed.

Kemp et al. (2013) employed an existential-phenomenological approach to consider EE, weight loss and maintenance goals. Thirteen participants took part in open-ended individual interviews. The researchers also interviewed people who do not emotionally eat. Following analysis, 'eating to manage negative emotions' and 'pre-factual thinking and rumination' were identified as major themes in addition to pressure from 'social norms'.

The study above had an all-female sample, as is the trend in obesity and EE research. In contrast, Foran (2015) used grounded theory to explore the under-reported experiences of men who emotionally eat. Thirteen participants took part in semi-structured interviews; the findings illustrated participant conceptualisations of EE as a means of coping with struggles regarding masculinity and EE to cope with difficult emotions. Reflecting on the work, Foran states using grounded theory provided flexibility but suggests further work in the area may benefit from an in-depth exploration of EE using discourse analysis and or phenomenological study.

My review of the literature did not find any studies aiming to explore the lived experience of EE where participants were specifically recruited from a UK specialist weight management service.

1.4 Support for Emotional Eating and living with obesity and Emotional Eating[1]

Where offered, weight management services are reported valuable by service users (Hughes, 2015). However, there are people for whom interventions have not helped and others who lose a significant amount of weight but subsequently regain it (Canetti et al., 2009; Elfhag & Rössner, 2005; Unal et al., 2019). EE is often cited as a reason for weight regain, and more understanding is needed to help services devise appropriate support interventions tailored towards reducing this risk (Abramson, 1993; van Strien, 2018a).

[1] A contextual overview of current UK NHS provision for obesity/weight management and intervention for EE is provided in appendix A.

Studies looking at lived experience among patients attending NHS services for weight management are rare. Work by Owen-Smith et al. (2014) (referred to in section 1.1.3) provides a rare exploration of participant accounts of developing and living with obesity (n=31) that recruited from an NHS weight management setting. Analysis of in-depth interviews used a constant comparative method and then grounded theory. The research highlighted shame and emotional distress contributing to ongoing obesity and called for more compassionate and inclusive healthcare for people living with 'extreme' obesity.

Psychological Support for Emotional Eating

Ideally, weight management services should offer integrated psychological care matched to an individual's specific need (Annesi et al., 2016; BPS, 2019; Cassin et al., 2018a). However, neither obesity nor EE are formally conceptualised as psychological conditions, and therefore no evidence-based guidelines exist on best practice for managing EE (Brownwell & Walsh, 2017; Larkin et al., 2017; Marcus & Wildes, 2009) and Annesi et al. (2016) described EE interventions to mostly be 'atheoretical' p. 289. Work is needed to develop a theoretical framework for fully integrative psychological care, including intervention for EE (Cassin et al., 2018b; Sogg et al., 2018).

Research focusing on EE intervention is growing (Annesi & Johnson, 2020; Juarascio et al., 2020). Strategies to support emotional regulation taken from Dialectical Behavioural Therapy (DBT) (Braden et al., 2020; Braden & O'Brien, 2020) and Acceptance and Commitment Therapy (ACT) (Forman & Butryn, 2016; Hill et al., 2015; Litwin et al., 2017) are showing promise, but longitudinal work is lacking. Halvgaard (2015) documented a single case study where EE in a fifty-five-year-old woman decreased following eye movement desensitisation and reprocessing (EMDR). Overall much more work is needed to develop interventions for EE; however, integration of mindfulness and Compassion Focused Therapy (CFT) with traditional CBT for EE has started to be utilised with some success (Carter et al., 2018; Goss, 2011; Mantzios & Wilson, 2015).

The BPS has recommended that NICE guidelines be updated to include clear evidence-based guidance addressing psychological factors perpetuating a person's

struggle with obesity, including past traumas, ‘comfort eating’ and emotional regulation (BPS, 2019). Further ongoing research to increase understanding of how people experience their EE and any previously tried strategies is needed to help inform such guidance.

1.5 Summary

Reviewing the literature has shown EE to have complex and multi-faceted understandings. EE spans psychological perspectives, with theory drawn from biological, cognitive, social, evolutionary and psychodynamic schools of thought. Therefore, an integrated approach is needed to design further research and interventions for EE (Schepers & Markus, 2015). To date, much work on EE has been quantitative, and this has helped to raise research interest in an area of research associated with obesity that has previously been ‘overlooked’ (McFerran & Mukhopadhyay, 2013). Studies have identified clinically relevant areas for further research (see Litwin et al., 2017). However, there are methodological concerns with the current research base. Allison & Heshka, (1993) argue potential bias is introduced to EE studies that rely on self-report, including possible recall bias and difficulties controlling confounding factors, e.g. social desirability. Overall, research into EE lacks population diversity, with many studies having recruited white middle-class American, undergraduates and all-female samples (e.g. Annesi et al., 2016; Celec, 1994; Strodl & Wylie, 2020). It is also often the case that samples are taken from general populations, limiting clinical generalisability.

Gaps in the Literature

Qualitative studies on EE are much fewer in number than quantitative. Those reviewed provide an interesting insight into EE, although they often do so through a specific theoretical lens (e.g. Hernandez-Hons & Woolley, 2012), which may obscure important aspects of participant realities.

I have noticed little research describing accounts of EE as a lived process, i.e. knowledge of the thoughts, feeling, behaviour and body sensations experienced before, during and after eating. Understanding more about the experiential process of

EE may have clinical implications, particularly given the current focus on awareness and mindfulness-based intervention (Mantzios & Wilson, 2015; Yu et al., 2020).

Theoretical conceptualisations of EE in the literature are varied, and interest in its relationship to obesity is growing. However, there is still a lot for us to learn regarding how best to support people whose attempts to lose weight are impeded by EE. In general, literature informing specialist weight management services remains sparse (Hughes, 2015), and further research is needed to explore how people who tend to emotionally eat make sense of their eating both as a process and in the context of living with obesity. Hearing this type of 'socially situated knowledge' directly from service-users can facilitate invaluable 'bottom-up' understanding, both of the construct under study and of service-users lived realities (Cooper, 2001; Haraway, 1988). Such understanding is currently scarce in the literature, particularly from service-users attending NHS specialist weight management services.

Overall, the research reviewed shows EE to be a regular part of life for many people who live with obesity. There is, however, still truth in Dalton's (1997) position that EE lacks 'definitional precision'. This lack of specificity is perhaps partly due to the paucity in research exploring how people who experience EE define and conceptualise the construct.

1.6 Current Study and Research Question

A decade has passed from calls made by a BPS working group for further research to establish an "in-depth understanding as to why an estimated 1.3 million obese individuals use food for affect regulation" (2011, p. 81). While research into EE has increased, a greater and in-depth understanding of it remains urgent. This research hopes to contribute to understandings of EE in the context of living with obesity by exploring conceptualisations and foregrounding the lived realities of service users. As such, my research has been guided by the following question:

> *How do patients under the care of an NHS tier 3 obesity service experience and make sense of 'emotional eating'?*

Chapter 2: Methodology

"the body is our general medium for having a world" - Merleau-Ponty

2.1 Introduction

Methodology details the plan for a study and inevitably grows from the researcher's ontological and epistemological assumptions (discussed in section 2.2), which, in turn, apprise processes and procedures (Hitchcock & Hughes, 1995; Rennie & Smyth, 2015). I have aimed to provide an accurate account of the procedure followed and reasoning behind the decisions taken to ensure that the methodological strategy suited the research question, namely:

> How do patients under the care of an NHS tier 3 obesity service experience and make sense of 'emotional eating'?

The chapter outlines processes that have ensured that this research is ethically sound and discusses how reflective and reflexive practice has been incorporated into this process.

2.1.1 Research Rationale and Aims

Despite being a frequently reported part of life for many people living with obesity, emotional eating (EE) is poorly defined in the literature and conceptualised in many ways by researchers and clinicians (Dalton, 1997; Mantau et al., 2018). However, conceptualisations of EE held among people who emotionally eat are generally overlooked (see chapter 1) and particularly so for people who attend specialist weight management services in the UK. These missing understandings likely include important knowledge, inherently grounded in embodied, personal and lived reality (Lizardo, 2013).

Learning about people's 'lived experience' can illuminate perspectives and illustrate how meaning has been ascribed to a situation by the person living it and expressed

through thought, emotion, behaviour, and the body (de Casterlé et al., 2011). Learning from service-user lived experience can lead to new, deeper understandings and enhance empathic commitment (de Casterlé et al., 2011; Finlay, 2009a). Furthermore, such awareness can help break down barriers, produce attitudinal change, reduce stigma and lead to findings relevant to clinical practice (Happell et al., 2019; Trivedi & Wykes, 2002).

Therefore, this research aimed to elicit in-depth descriptions regarding how EE is directly experienced and conceptualised by people living with obesity. My hope for the research was for interpretive understanding to emerge rooted in the voice of participants'.

2.2 Theoretical Position

The theoretical assumptions research is embedded within inform decisions taken throughout the research process (Thomas, 2013). This section begins by discussing why I position my research within a non-positivist paradigm and moves on to consider how this reflects my views on how knowledge can be revealed, including what I believe *'exists'* (my ontological position) and what I believe I can *'know'* (my epistemological position) (Crotty, 1998; Egbert, 2013). Discussion on how qualitative methodology fits with these positions closes the section.

2.2.1 Paradigm

There are some facets of EE and of obesity that arguably fit a positivist understanding of the world, in that empirical data can be observed, measured and subsequently used to build 'tangible' knowledge (Tracy, 2013). Interpretation of objective data relating to EE and obesity, e.g. using BMI measurements to categorise obesity and EE scales, nutritional profiling and food-mood diaries to collect functional and realist information (Aballay et al., 2016; Arnow et al., 1995) fit tenets of positivism. However, my research aimed to learn about people's experience, including how they *make sense* of times when they eat in response to emotions. The positivist paradigm could not offer me the space to explore such subjectivity.

If two people score highly on the EE scale (Arnow et al., 1995) and both have a calculated BMI of 40, this can only serve to tell us that both report regular EE and meet the current diagnostic criteria for severe obesity. No other information can be gleaned; the numbers *do* capture the *existence* of both EE and obesity, but they are unable to convey any *content* of what either phenomenon mean to each individual. In transcendental phenomenological terms, the underlying 'structure' and 'essence' is missed (Giorgi, 2009; Husserl, 1931; Moustakas, 1994).

Similarly, whilst two people may share the same 'scores', I believe they would make sense of their EE in unique ways by drawing on their individual belief systems and situated experience (Held, 1995; Willig, 2016). These experiences will naturally be varied and subjective; however, I do not believe that this excludes the possibility of *shared intersubjective understanding* between the two people.

Therefore, this research does not sit within a wholly positivist paradigm that in seeking 'single objective reality' does not accommodate our capacity to individually interpret and mentally represent experiences (Cohen et al., 2007; Denscombe, 2010; May 2011). Instead, I identify the research as non-positivist, allowing data to be collected 'beyond the tangible'. Non-positivism recognises that knowledge can take many forms, is cultural and acknowledges that it is produced through a relationship between "the knower and the known" (Guthrie, 2010, p. 43).

2.2.2 Ontology

Consideration of ontological position bids us to think about existence and examine the world's nature and reality (Cohen et al., 2007; Crotty, 1998). Hammond and Wellington (2012) warn that without sufficient consideration of ontology, research can lose coherency. Therefore, ontology is paramount in shaping psychological research, developing research questions, conceptual bases, and procedural steps (Hammond & Wellington, 2012).

The notion of an 'independent reality' is fundamental to ontological debate and has been described as the reality that does *not* originate from the "conceptual, linguistic or

narrative constructions" of the person who possesses the knowledge, i.e. the "knower" or from their cognitive processes (Held, 1995, p. 306). Independent reality can be considered objective because its existence is separate from the subjective world of the 'knower' (Held, 1995). A 'realist' ontological stance resolutely argues that 'independent reality' exists and is objectively accessible (Hansen, 2004; Held, 1995; Willig, 2016). The polar radical 'relativist' view does not consider reality to exist beyond the subjective; knowledge of independent reality is considered impossible (Held, 1995; Willig, 2016).

Reflections on my 'ontological position':

If I ask myself, 'does emotionally eating exist?'; I can answer 'yes' and refer to my own experiences to confirm what I know of the phenomenon (Ponterotto, 2005). Therefore, my research began from the fundamental assumption that 'EE' is a phenomenon that I know exists. I also assumed that other people exist who hold their own experiences and realities of EE. I fully accept that no one can know completely how someone else subjectively experiences EE or exactly what that experience means to them (Smith, Flowers, Paul, et al., 2009). However, I also believe that our human lack of omniscience must not undermine the existence of other people's experiences or deem learning about these experiences completely inaccessible. As such, I do not align myself with the ontological relativistic position that no 'independent reality' can exist beyond my own mind.

2.2.3 Epistemology

The 'epistemological position' held by a researcher also steers methodology; it is concerned with what we *can* know, *how* this knowledge can be acquired and how we *validate and demonstrate it* (Cohen et al., 2011; Mason, 2018; Willig 2008). In addition to the assumptions detailed previously, planning my study assumed that the people offering to participate would be able to refer to their own experiences and realities of EE and furthermore would be able to construe and communicate these to me through language.

Reflections on my 'epistemological position':

I find the psychology of how we form, choose and use language fascinating and fully agree with the growing call for urgent work to review how language use can help frame sensitive, non-alienating and inclusive weight management services (BPS, 2019). In this respect, I agree with the social constructivist assertion that language use is or (perhaps *'can be'*) a form of social action (Burr, 2003). I also believe that the language we use to construct a phenomenon perceptibly impacts its meaning. However, I do not consider language to be the sole constituent of phenomenological meaning or exclusive determinant of how it is experienced. Similarly, whilst I believe that language is extremely influential to how we construct our social worlds throughout life, I find radical social constructivists ideas on language as a pre-condition for thought difficult to accept (see discussion in Burr, 1995). Group psychology shows us how undeniably powerful collective thought and shared experience can be (Tajfel, 1979). However, I find the social-constructivist position that knowledge and reality are entirely a product of the social aggregate (Gergen, 1985; Held, 1995) difficult to reconcile with non-positivist emphasis on subjectivity (Hansen, 2004). Whilst keen to listen for overall experience in participant accounts of EE, I did not want the individual to risk becoming submerged by my methodology. In positioning my research as non-positivist, I do not deny the possibility or utility of objective knowledge. I believe we can acquire knowledge that is objective, knowledge that is subjective and, as Moustakas (1994) suggests, knowledge that can include the *intertwining* of the subjective and objective. As such, my epistemological position leans towards critical realism.

This study, therefore, began from a relativistic epistemological base. Critical realism ontologically accepts that the world is comprised of different parts that include objective causal mechanisms and diverse perceptions independent of individual reality; it also acknowledges individual subjective experience (J. Mason, 2018; Maxwell, 2012) (Mason, 2018; Maxwell, 2012). Critical realists consider individual experience to extend beyond social constructs and acknowledge that reality can never be known in an absolute or singular totality, and therefore multiple perspectives are possible (Bhaskar, 1975; Guba & Lincoln, 1994).

A researcher needs to consider their role in how the knowledge a study produces is acquired (Cohen et al., 2011). Acquiring knowledge of the experiences and understandings people hold of EE required me to 'interact' with the research and interpret participant accounts (Creswell, 1994). Therefore, the participants and I were arguably co-constructors of the findings, with potentially multiple social values, belief systems, preconceptions, and prior experience being brought to the construction process (Bell, 2013; Walliman, 2017). The extent of my interpretive involvement within the research made reflexive process particularly pertinent (see section 2.8).

2.2.4 Qualitative Methodology

The literature search yielded significantly more quantitative studies on EE than qualitative (see chapter 1) and highlighted that EE's theoretical considerations are multiple and varied, spanning several major psychological schools. Such variety implies some aspects of EE suit quantitative investigation (e.g., neurochemical correlates or behavioural analysis), but other aspects are arguably too composite and personal for a quantitative approach to capture.

This study focuses on experience and meaning-making; therefore, it suits a qualitative study that can provide 'rich' and 'realistic' descriptions (Miles & Huberman, 1994; Willig, 2008). Furthermore, qualitative study did not require the complexities of EE to be reduced. Lincoln and Guba (1985) explain that qualitative research methodology accommodates those social realities that "are wholes that cannot be understood in isolation from their contexts, nor can they be fragmented for separate study of their parts" (p. 39).

Qualitative research understanding arises through a three-staged process involving description, analysis and interpretation (Wolcott, 1991). Therefore, a qualitative study was fitting for research that assumed that multiple meanings of EE would likely be uncovered and anticipated that data generated from first-hand accounts of experience may provide 'deep' and 'thickened' understanding of the phenomenon (Henwood & Pidgeon, 1992; McLeod, 2015).

2.3 Methodology

2.3.1 Phenomenology

Phenomenology draws on the philosophy of Husserl (1927), who considered conscious awareness (including awareness of objective understanding) to be mediated through our subjective experiences of phenomenon and therefore necessitates a 'phenomenological attitude' that foregrounds subjective experiences (Smith, Larkin, & Flowers, 2009). This perspective is in keeping with the epistemological position informing the research; it accepts objective reality exists whilst also accounting for subjective and contextual experience (Larkin et al., 2006; Smith et al., 2009). Furthermore, the idiographic stance allows existing research to be conceptually explored and built on (Smith et al., 2009).

The research question focuses on how EE is experienced and conceptualised by those who experience it. Whilst maintaining that complete knowledge of another individuals experience is not possible, the question fits with the assertion of Lydall et al. that phenomenological study seeks:

> "to answer the fundamental question of what the experience itself is really like and what it is about the experience that renders it significant."
>
> (2005, p. 2)

In phenomenological research, the 'uncovering' of a person's unique 'lived' reality is facilitated by the researcher encouraging participants to share accounts of experience that are descriptively 'rich' (Langdridge, 2007a; Somekh & Lewin, 2005). I hoped that this attention to detail would allow me to present the participants' experiential meaning through "fresh, complex, rich descriptions…as it is concretely lived" (Finlay, 2009b, p. 6) and offer authentic findings of the complex phenomenon of EE (Denscombe, 2010a).

Whilst phenomenologists agree that phenomenology's central aim is to present embodied, experiential meanings through rich description, three broad approaches have emerged: descriptive/transcendental phenomenology, critical narrative analysis, and interpretive phenomenological analysis (IPA) (Finlay, 2009a; Langdridge, 2007a).

Descriptive or transcendental phenomenology uses phenomenological reduction to describe the 'essence' of an idiographic experience at a general level (Denscombe, 2010a; Finlay, 2009a; Langdridge, 2007a). There is no need for interpretation, and all details of the phenomenon are considered to have equal value (Davidsen, 2013; Langdridge, 2007a).

Critical narrative analysis (CNA) has been developed by Langdridge (2007) and examines participant stories within accounts of an experience to consider how such stories construct experiential meaning (Langdridge, 2007b). Langdridge (2008) builds on the work of Ricoeur (1986) in highlighting the role of political and social change in how we experience the world. CNA incorporates the hermeneutic of 'suspicion' into the analytic process, providing increased critical focus by introducing an additional lens (usually social or political) to interpret through (Davidsen, 2013; Langdridge, 2008), which Langdridge (2008) argues encourages fuller critical interpretation by allowing new possibilities to open rather than uncovering a 'hidden truth'.

2.3.2 Interpretive Phenomenological Analysis (IPA)

IPA seeks to systematically explore how people ascribe meaning to experience (Smith, Larkin, et al., 2009). Rooted originally in Heidegger's ideas on hermeneutics, social reality is considered to arise from an interpretive process inescapably influenced by the idiographic (Dash, 2005).

Analysis in IPA is therefore iterative; and described as a 'hermeneutic cycle' with interpretation continually moving between a focus on the 'parts in relation to the whole' and 'the whole in relation to the parts' (Gadamer, 2004). The researcher and participant are considered to be in a double hermeneutic, wherein the researcher attempts to *make sense* of the participant trying to *make sense* of their own experiences (Smith et al., 2009). Inevitably, participants and researchers bring their own social understanding and other contextual and conceptual knowledge to the process that is acknowledged and reflected on in IPA (Larkin et al., 2006).

Heidegger (1962) emphasised that the researcher is a 'being in the world' and embedded in the research. Merleau-Ponty (1964) refined Heidegger's thinking and emphasised the body's role to experience; reasoning, that our sense of self, body and

experience is inextricably linked and, therefore, all relationships with the world (including research) are embodied. Embodiment, Merleau-Ponty argued, explains our inability to completely know another's experience because we are all positioned within our own embodied viewpoint (Smith et al., 2009). However, from that embodied viewpoint, we are also able to perceive and use perception as a path to "access to truth" (Merleau-Ponty, 1962, p. 16). IPA takes the embodied reality of both participant and researcher into account.

There is criticism that phenomenology concentrates too much on description; IPA, however, is arguably dualistic. It presents both idiographic experiences in addition to identifying 'higher-order qualities' and interpretations shared across participants (Larkin et al., 2006; Smith et al., 2009). While committing to individual and authentic experiential description, the methodology can 'go beyond' the data in its analysis, allowing interpreted shared meanings to be contextualised and considered (Larkin et al., 2006).

Why IPA over other phenomenological methodologies?

Descriptive phenomenology may have been appropriate if I were looking to understand a particular aspect of EE, but this research intended to consider EE per se in the context of people struggling with severe obesity. Husserl (1927) suggested that achieving pure description requires the researcher to bracket their assumptions through the process termed epoché. I find the intention in IPA to engage in active reflection a more realistic invitation than the call to bracket my position off completely. IPA can acknowledge the researcher's subjectivity and their role in the research.

The participants are drawn from a population often overlooked, and it was particularly important to the studies rationale that their voice was not lost. For this reason, I initially considered using critical narrative analysis, finding the focus on life stories to be particularly appealing for research that wanted participant voice to be central. However, I had concerns that a heavy focus on language construction and introducing an additional lens to the analysis may distract from the studies experiential and conceptual emphasis. IPA allows scope to consider the many layers of experiential reality (e.g. cognitive, affective, behavioural, embodied) (Finlay, 2011).

My review of literature on EE and experience of working at a weight management service has led me to believe EE to be a multifaceted and personal experience. IPA has the advantage of being able to descriptively illuminate complex phenomena whilst retaining the value of idiographic experience (Denscombe, 2010b; Langdridge, 2007a) and capture “shared experience at the heart of the investigation” (Langdridge, 2007a, p. 58). IPA was particularly appropriate given the small homogenous sample I had access to and the added benefit of being low-cost (Denscombe, 2010b; Langdridge, 2007a).

Why IPA over other qualitative methodologies?

Many qualitative methodologies seek an understanding of individual experience. Grounded theory was a considered option, also being iterative and recognising the researcher's role in a double hermeneutic (Rennie, 2000). In grounded theory, this relationship is considered and used in the generation of theory, and hypotheses can be formulated directly from the data for further study (Charmaz, 2006). A point can be reached of ‘understanding that around us’ that is more ‘absolute’ than some other qualitative methodologies (Glaser, 2005). Given that the current study did not intend to generate theory and that the research question suited an ‘open-ended’ exploration of personal context-specific experience, I considered the flexibility IPA can offer to be more appropriate.

Using discourse analysis to look at how participants construct their understanding of EE through language was also considered (Potter & Wetherell, 1987) and may be an interesting methodology to explore EE further. However, for the aims of this current research, I felt IPA was better able to consider a wide array of experiential process and meaning-making rather than limiting attention to construction through language. Having space in IPA to explore embodiment also made IPA salient, given that both the subject and context of the research relate to the body.

2.4 Ethics

Research conducted ethically ensures that participants are protected and respected, the research process is not undermined, and the researcher's integrity is not compromised (Cohen et al., 2007; Haverkamp, 2005). In this section, I outline the steps taken to ensure that this research is ethically sound and adheres to the BPS 'Code of Human Research Ethics' (2014)

2.4.1 Ethical Considerations

It is a researcher's responsibility to remain "ethically attuned throughout" (Carla Willig, 2008, p. 20). Whilst developing the research strategy, I had opportunities to discuss its ethical implications in peer, clinical and research supervisions, and attention to ethics remained an ongoing evaluative process (Smith et al., 2009; Willig, 2008). The four underlying principles for ethical research practice set out by the BPS (2014) have informed and structured my ethical planning as detailed below:

1. Respect for the Autonomy and Dignity of Persons

In ethically sound research, participants' autonomy must be maintained at all stages; participation must be at the participants' own will, with no fear of coercion (Association for Research Ethics, 2013; BPS, 2009). Equally, participant dignity must be maintained and the researcher transparent (BPS, 2014). A particular concern in planning the project related to the potential participants may have felt obligated to take part because the research was conducted through the service they attend as patients. To help ensure that people did not feel under duress, I emphasised in all communication with participants that their involvement was completely separate from their clinical care and that choosing to take part or not would have no implications for their ongoing treatment.

Participants were frequently reminded that they had the right to withdraw from the study, without needing to provide a reason, up to the point of write up. Before the interviews started, I showed participants that I was starting the recording (for interviews conducted via video call, this was done in front of the camera, for the phone

interview, this necessitated verbal comment only). Participants were reminded that they could pause or stop the interview at any stage. With interviews that took place in person, I positioned the recording device within reach of the participant.

Consent was sought at the initial stage of expressing interest and again immediately before the interviews by participants completing a written consent form completed by the participant (see appendix B) and signed by us both. It was important participants had a full understanding of the aims, purpose and potential consequences of the research so that their consent could be considered informed (Thompson & Russo, 2012). A detailed participant information sheet (PIS) was given to participants in the initial information provided (see appendix C). This included explanation of what taking part would involve and what would happen to information shared. I verbally summarised this information during my initial phone contact with potential participants who had expressed interest in the research, and this conversation also served as an opportunity to explore if taking part felt comfortable. Participants were invited to ask questions whenever we had contact. Participants kept a copy of the consent form and another copy retained by myself. When the study switched to remote interviewing (see 2.4.2), consent forms were emailed securely between myself and the participants. The completed forms were stored securely, and all emails deleted.

Confidentiality was upheld with the same cruciality as in clinical work, including ensuring participants were aware of its limits, e.g., should a disclosure be made suggesting risk to themselves or others. All participants were assigned a non-identifiable code at the recruitment stage for use in my notes and journal. Participants names were changed during transcription along with any other potentially identifying information. Interviews were recorded using an encrypted digital sound recorder. After the interviews and debrief, the mp3 audio files were transferred to a secure storage system, password protected and removed from the recording device. Files were saved without including information relating to participants personal details.

Guidance on meeting General Data Protection Regulation (GDPR) requirements was followed (Information Commissioner's Office, 2018). During recruitment, the service administrator sent packs to potential participants, including invitation letters (see appendix D) and the PIS, ensuring that individual addresses and telephone numbers were not disclosed to me without patient consent.

Participants were reminded that they had the right to see any information kept on them and the right for all information concerning them to be destroyed should they choose to withdraw. The PIS clearly outlined how participant data was to be treated and stated that anonymised extracts from the interview would be included in my thesis and any presentations or publication relating to it.

2. Scientific Integrity

Ethicists advise that matching methods appropriately to the remit inferred by the research question determines the studies value (Demuth, 2013; Willig, 2008). The research has been fully supervised throughout, scrutinised via NHS ethics procedure and discussed with peers through the doctoral programme research seminars contributing to its integrity (Thompson & Russo, 2012). The evaluation process included presenting design decisions to peers, practitioner psychologists and 'experts by experience' at a research progress review in May 2019.

3. Social Responsibility

BPS ethical code of conduct (2014) emphasises the importance of working within the limits of professional competency. Participants were aware that I am a trainee counselling psychologist and that the research would be assessed as part of the research portfolio required to complete my professional doctorate. Participants were informed in the PIS that should I be worried about their physical or psychological well-being due to something disclosed, I would immediately raise my concern. Using tools and activities to aid reflection (see section 2.8), e.g. keeping a research journal, helped keep me alert to my social and ethical responsibilities.

To assure participants of my accountability, they were provided with contact details for my supervisors should they have any concerns about my conduct. Following R&D review, the local PALS contact details were also added to the PIS document should participants have wished to speak to someone impartial.

Implications associated with dissemination forms an important part of the social responsibility accompanying psychological research (Iphofen & Tolich, 2018). Practical considerations include ensuring findings are presented in an accessible way

and providing participants enhanced anonymity, e.g. keeping transcript extracts brief (Thompson & Russo, 2012).

Participants can have expectations in terms of dissemination, e.g. people may agree to take part because they perceive the research important and show a willingness to discuss painful and personal issues because they consider the impact of the research may be 'worthwhile' (Allmark et al., 2009; Graham et al., 2007) and I will look to disseminate findings as appropriate. I presented the research rationale and aims to MDT colleagues during a service meeting.

4. Maximising Benefit and Minimising Harm

The protection of participants has remained a priority. With consent, I wrote to each participants GP and provided my contact details should they have concerns about their patient's involvement (see appendix E). No one was invited to participate who was considered at increased psychological risk or had limited capacity to give informed consent (see section 2.5.2 for inclusion and exclusion criteria). Potential participants were only invited to take part following their clinical assessment by a senior psychologist.

Aware of the imbalance of power that can arise in the dynamic between participant and researcher, participants were reminded that they could let me know if they did not wish to answer a question or wanted to stop the interview (Allmark et al., 2009). Each participant specified times convenient for contact and scheduling interviews.

While my primary role was not to advise, I was aware that circumstances could arise where a participant raised questions or concerns unrelated to the research. Participants were advised that I had details of other sources of support should they feel this was needed and given details of a psychologist at the service to be contacted should they have experienced distress due to their involvement.

2.4.2 NHS Ethical Approval Process

The research involved qualitative exploration of an emotionally sensitive topic and recruited participants from an NHS tertiary care service. Therefore, before recruitment,

the study underwent NHS ethical review. Clearance was subsequently granted by the South East Scotland Research Ethics Committee (SES REC), the Health Research Authority (HRA) and the local Research and Development (R&D) team at the NHS Trust of the service used for recruitment (NHS HRA, 2021).

Please see appendices F to K for documentation relating to the ethical review process, including minor changes made prior to clearance and minutes from the SES REC review committee.

2.5 Procedural Aspects

The procedural aspects of research outline how a study is organised (McLeod, 2015). Section 2.5 details the procedural aspects of this research, from recruitment through to interviews.

2.5.1 Sampling

The sample drew from patients currently attending the weight management service at anonymisedchunkoftext NHS Trust. At the time of recruitment, I was working at the same service as a trainee counselling psychologist. The research sought to uncover in-depth idiographic information rather than generalisable understandings; sampling was, therefore, purposive and homogenous. Purposive sampling allows researchers access to people who possess in-depth experiential knowledge of a topic that serves the specific needs of the research (Cohen et al., 2011) and allowed me to invite people who frequently emotionally eat. The sample was homogenous in that the group of people sampled shared characteristics (Miles & Huberman, 1994), i.e. all reported frequent EE, all had been diagnosed as clinically obese, and all were seeking help to lose weight.

In general, phenomenological research keeps small sample sizes to allow themes to emerge from rich detail of lived experience without creating an overwhelming amount of data (Langdridge, 2007; Smith et al., 2009). Langdridge (2007) advises that a sample size of between four and six participants is sensible when undertaking

phenomenological research. In adherence to this guidance and given the relatively short timeframe for running interviews, six participants were recruited to the study.

2.5.2 Participant Identification

The anonymisedchunkoftext service lead psychologist identified potential participants who met the initial inclusion criteria. All had attended a full psychological assessment as part of their clinical care, also conducted by the lead psychologist. During the assessment, a tendency to 'emotionally eat' has been noted based on the information provided in the referral, history at assessment and score on the Emotional Eating Scale questionnaire (Arnow et al., 1995), which is one of several instruments completed routinely during the first appointment attended at the service and does not require interpretation (see appendix M). At this assessment, patients had agreed to be contacted about current research projects at the service.

Therefore, the inclusion criteria specified participants having been recently assessed by a psychologist and EE having already been identified. Inclusion criteria also stated participants had a BMI of 35 or over and were aged over 18. There was no upper age limit for taking part. Patients considered vulnerable by the lead psychologist were not invited to participate and included those currently suffering from poorly controlled depression, anxiety or other mental health difficulties (screened using PHQ9, GAD7 measurements taken prior to interview). People who had expressed suicidal ideation or who were engaging in deliberate self-harm were excluded. People whom I was due to begin individual therapeutic work with were excluded. No participant was excluded due to gender, ethnicity, religion, sexuality, social status or disability.

2.5.3 Invitation to Participate

Information packs were compiled and sent to potential participants by the administrator of the service. The packs included a letter of invitation (see appendix C), a PIS (see appendix B) and an expression of interest form together with a stamped addressed envelope for 'opting in' by post if preferred to email contact. I endeavoured to use language that conveyed warmth, had a non-judgemental tone and was not pressurising in the invitation letter. It was emphasised in the letter, the PIS, and the

footer of any emails sent that patient care and treatment at the anonymisedchunkoftext service remain independent from the research study, and there was no obligation to participate.

2.5.4 Contact with participants before interviews

Three points of contact occurred between myself and the participants before the interviews. All potential participants emailed me directly to express interest in taking part in the study. I responded to each email by thanking people for their interest and asked when it would be convenient for me to call and discuss further what taking part would involve. If happy to do so, participants provided me with their phone numbers and suggested times to call. Following our phone conversations, two people decided not to participate; I thanked them for their interest and reiterated that not participating would have no impact on their clinical care. For those happy to go ahead, I emphasised that they had the right to change their minds and withdraw from the study at any point up until when I started writing up. At the end of the call, provisional appointments for the interviews were arranged. We agreed that I would make email contact on the morning of the interview, confirming arrangements were still convenient for the participant and attaching the consent form. This interim time also served as a 'cooling-off period' should participants have decided they wanted to withdraw. These points of contact allowed rapport to build before the interviews.

2.5.5 Site

The location of where interviews take place can have potential implications, especially for perceived power dynamics (Hoffman, 2007). Initially, participants were asked to choose where would be most convenient to meet for face-to-face interviews; options included meeting at anonymisedchunkoftext hospital, participants homes or another quiet location suggested by the participant.

In line with national measures during the first national lockdown of the COVID-19 pandemic, participants were interviewed remotely from April 2020 onwards via telephone or video call (dependent on participant preference). I took care to be mindful of the additional measures needed to protect participants when working online or on the phone, e.g. ensuring I was calling from a room where I was alone, could not be

overheard and would not be disturbed (see LoIacono et al., 2016). The R&D team granted this minor amendment on 26.3.20 (see appendix L for notification), and the PIS updated.

2.5.6 Lone Working Safety Planning

Anonymisedchunkoftex policy on lone working was followed. When each interview concluded (including those conducted remotely), I made immediate contact with my clinical supervisor, who was aware of when and where I was interviewing. It was arranged in advance that if I did not make contact as expected, she would try to contact me and follow up as necessary.

2.5.7 Data Collection

Semi-structured interviews aimed to elicit rich, 'in-depth' information regarding how participants experience and make sense of their EE. The use of 'semi-structured' interviewing is considered particularly appropriate for a phenomenological study, allowing them to steer the discussion towards aspects of their lived experience they feel important to share (Bouma, 2000; Langdridge, 2007; Woodgate et al., 2008). Encouraging participants to speak freely in this way preserves autonomy whilst also providing 'descriptive accuracy' (Alvesson & Kärreman, 2011).

Whilst acknowledging semi-structured interviews as being the most frequently used method of data collection in IPA research, Langdridge (2007) describes them as bringing "a trade-off between consistency and flexibility" (p. 65). As previously discussed, this research is not attempting to make generalisable statements but is idiographic and favours the flexibility that semi-structured in-depth interviewing brings.

Thomas (2013) comments that for some people writing their experiences in a diary is more comfortable than speaking face-to-face with a researcher. For this reason, and with the view of broadening the data collected, I considered using diary studies in addition to interviews. However, during my placement at the anonymisedchunkoftext service, I have observed patients frequently expressing frustration and distress with food and mood diaries they are asked routinely to keep, sometimes reporting them to

feel overwhelming and shaming. I have had an ethical responsibility to minimise the likelihood of distress occurring from participation in the research and therefore opted only to conduct interviews, keeping the response burden low (Denscombe, 2012).

2.5.8 Interview Schedule

Open Questions

I avoided asking leading questions that could 'telegraph' my perspective over the participants and introduce interviewer bias (Bell, 2010; Mears, 2009; Roulston, 2010). Open questioning also helped reduce potential power imbalances encouraging participants to speak openly and be situated as the 'expert' in the room (Hoffman, 2007; Reid et al., 2005).

Interview Schedule/Agenda

The interview schedule provides a framework of issues pertinent to the research with possible questions and probes to be referred to as needed (McLeod, 2015). I compiled a loose agenda comprised of open questions relevant to the research question and prompts. The schedule was based around three main areas relating to the research question, namely, *'the thoughts, feelings and embodied experience of EE'*, *'beliefs and understanding of EE'* and *'impact on life'*. Within each area, I listed open questions, e.g. "Is it possible to describe a recent example of a time when you ate in response to how you were feeling?" and funnelled towards more specific closed questions with prompts if needed (see appendix K).

A small group of service-users who attend a psychoeducation group I co-facilitated were invited to look at the schedule and provide feedback and suggestions. Service-users understood this was a voluntary task. Feedback was positive, and several service users commented that they were pleased research attention was being paid to EE.

The interview schedule provided a skeleton structure, maintaining some consistency across interviews. However, the semi-structured format also allowed me to be guided by the participants narrative and afforded flexibility for tailoring questions accordingly.

I explained to participants that I had a list of questions that I may refer to but that they served as a guide rather than a rigid timetable.

2.5.9 Interview Process

Interviewing has been described as a ‘craft’ reliant on the ‘social relationship’, ‘rapport’ and ‘safe space’ established between interviewer and interviewee (Booth, 2008). Thomas (2013) describes building rapport as a process but where a researcher proves they are human. Building rapport began from the first contact with participants. Before starting each interview, I re-introduced myself and made light conversation to put participants at ease. We also worked through the consent form together before signing.

To help facilitate a ‘safe space,’ I reiterated participants rights to withdraw from the study and recapped what would happen to the interview recordings, asked if they had any questions and checked they were comfortable before we began. For the face-to-face interview at the hospital, I ensured the room was set up with chairs arranged to avoid connotations of formal job or clinical interviews. I reminded participants before we began that the interview method I used concentrates on what they have to say and so not to be alarmed if I said relatively little in reply (see Smith et al., 2009).

Once the participants indicated that they were ready to begin, I started the audio recording and indicated this to the participant. When the interviews finished and participants were aware that the recording had stopped, I provided a debriefing sheet (see appendix O), and participants had the opportunity to talk about the interview and ask questions.

2.5.10 Cost

The financial cost of the research was low. The only expenditure was for stationary, stamps and printing, which amounted to no more than £10.00.

2.6 Participant Information

Thompson and Russo (2012) advise that it is good ethical practice to avoid the use of specific personal demographic data about participants. With this in mind, table 2.1 provides some background information about the participants without compromising anonymity.

Name	Aged > 50	Aged < 50	Currently in employment	Interview Location
David		✓	✓	Hospital
Iris	✓		✓	Home
Tish	✓		✓	Online
Todd	✓		✓	Phone
Nicole		✓		Online
Ellaine		✓	✓	Online

Table 2.1 Participant background information.

2.7 Analytic Procedure

IPA does not prescribe a definitive analytic method, allowing the analysis to be conducted in a way considered most appropriate to the research's specific needs (Smith et al., 2009). However, thematic analysis tends to be the analytic device most often used in IPA (Langdridge, 2007).

2.7.1 Verbatim Transcription

Smith et al. (2009) advise a verbatim transcription produces a 'semantic record' of the interview, documenting everything spoken by everyone present and can familiarise the researcher with the data. I completed transcription myself and, once transcribed, rewound recordings to check the data had been transcribed correctly; marginated and added line numbers ready for analysis.

Reflections on 'spoken' transcription:

I routinely used 'speech to text' software and did so for much of the transcription for this study which involved listening to the recording through headphones, pausing the recording and repeating the participants' words through a microphone. I had not originally used the software to aid my immersion in the data but found 'speaking' the participants' words out in this way powerful and emotional.

2.7.2 Stepwise Analysis

The analytic procedure detailed in the steps below was followed; the interviews were transcribed verbatim at the end of data collection. These stages are based on the suggested procedure by Langdridge (2007) and Smith et al. (2009). As a researcher new to doctoral-level study, I found confidence drawing on experienced phenomenological researchers' outlines of the thematic procedure they follow. Taking a stepwise approach to analysis is also considered to promote rigour via "organised, disciplined and systematic study" (Moustakas, 1994, p. 103).

Step 1. Reading and re-reading

Continuing my 'immersion' in the data, I read through the transcript from the first interview several times. Becoming familiar with the data in this way is purported to increase researcher responsiveness to the text and centralise the participant in the subsequent analysis (Langdridge, 2007b; Smith et al., 2009; Smith & Eatough, 2007). Before moving on to the next step, I listened to the recording again whilst going through the transcript. Concurrently, I recorded any reactions I had in my journal; this helped identify my assumptions (Willig, 2008).

Step 2. Initial noting

The next step involved making exploratory notes (see appendix P). I find annotating using a word processor most practical and compiled a table in Microsoft Word with the transcript in the centre and a column on either side. The left side was used to make the exploratory notes. Systematically working through the transcript, I made three types of notes descriptive, linguistic, and conceptual. Descriptive remarks noted content that was of significance to the participant and avoided my own commentary.

The linguistic notes related to how the participant used language to describe their experience; these were underlined to distinguish them from descriptive and conceptual notes. The conceptual notes detailed tentative points to highlight any questions I felt the text raised; these notes were italicised. Continuing to document any personal reactions that I had in the journal helped me remain open-minded.

Step 3. Developing emergent themes

At this stage, I began to bring my interpretations to the data. The transcript and initial notes were re-read, and I checked that they retained what the participant had said. Any preliminary 'emergent themes' were noted in the right margin (see appendix Q). These themes endeavoured to capture the text's complexity and richness whilst reducing the volume of notes. Any interpretations of mine were evidenced using the participant's words; this helped reduce researcher bias and improve rigour. In reading initial notes relating to a small proportion of the text whilst also keeping the context of the full interview in mind, the hermeneutic circle is entered, the transcript temporarily split into parts intending for the reconstruction of the 'whole' once the analysis complete (Smith et al., 2009).

Step 4. Identifying links between themes

Once emergent themes had been identified, they were individually listed in a word document chronologically. A second document was then created, which I used to start clustering together any themes that shared a connection. Themes were copied, pasted and rearranged within this 'clustering document', and the iterative process continued with my frequent re-reading of the transcript to check the emerging analysis. Superordinate and subordinate themes were identified and clustered together, depending on their meaning (see appendix R). Often subordinate themes were labelled by abstraction, and I tried to use the participant's language to word the themes (as per Smith et al., 2009). Sometimes a theme was subsumed into a superordinate theme, e.g., the superordinate theme for Tish's transcript *'EE is hugely powerful'.* Other times a superordinate theme was identified from polarisations in the data; polarisations and dichotomies were particularly evident in Iris's data, and this became a superordinate theme in itself. The frequency of a particular emergent theme also sometimes determined a subordinate theme, e.g. '*surrounded by secrecy and shame*'. On occasion, contextual information provided by the participant informed the

superordinate theme, e.g., from Nicole's transcript, the superordinate theme of *'missing social connection'* captured Nicole mentioning several times that missing family and friends during the national lockdown prompted EE.

Step 5. Graphical representation of emergent themes

The lists of emergent themes were checked against the transcript to ensure they were representative of the data. A table of emergent themes was drawn, including selected illustrative quotes for each theme from the transcript (see appendix S). If themes were not found to have sufficient support in the data, they were discarded.

Steps 1 to 5 were repeated for each transcript. Keeping to the IPA's idiographic intentions, I tried to keep my analysis of each transcript fresh and separate from themes identified in prior transcripts. I began working on a new transcript on a different day to finishing the previous and used my research journal to reflect on any possible assumptions I may have been holding between cases.

Cross Case Analysis

The list of superordinate and subordinate themes and the tables of supportive quotes from each participant were copied into Microsoft OneNote; allowing me to compare emergent themes across participants and reposition themes on screen as necessary (see Appendix T for screenshots). The process was guided by referral to questions suggested by Smith et al. (2009), encouraging me to consider connections across cases and look for times when themes from one transcript illuminated those in another. Superordinate themes from each of the cases were collected together as higher-order concepts; from which the overarching theme, principal superordinate themes and overall subordinate themes capturing the lived experience across all participants included in the study were identified.

Construction of master theme tables

Tables were drawn presenting the principal superordinate themes and their related subordinate themes. Further checking against the original verbatim transcripts took place, and extracts selected to illustrate the overall thematic findings evidencing their grounding in the data (see appendix U).

2.8 Reflexivity

Qualitative research (in particular, IPA) requires the ongoing reflexive engagement of the researcher throughout. Willig (2008) describes full reflexive engagement moving beyond a discussion of biases and invites us to: “think about how our own reactions to the research context and the data actually make possible certain insights and understandings” (p. 18). A crucial part of doing so involves considering where the researcher situates themselves within the research, particularly in terms of ideological, sociological, cultural and historical positioning (Finlay, 2016; Greenhalgh, 2010; Hammersley, 2007). Such reflexivity is critical to providing transparency. I included exercises to help prompt my reflexivity throughout the research process. The reflections documented in chapter 4 are informed in part from notes I made as part of (or soon after) the exercises discussed below.

Reflexive Research Journaling

Peoples (2020) describes reflexivity as “anticipating projections” and advises that journaling can be an effective part of the reflexive process necessitating “the revision for thought revision” therein becoming part of the hermeneutic circle (p. 65). Similarly, McCleod (2015) suggests recording in the journal “moments when the personal meaning of the research became apparent” (p.98). I logged my reactions to data, participants, literature and the overall research process. Before starting data collection, analysis and writing up, I worked through the questions devised by Langdridge (2007a) to promote researcher reflexivity and documented my responses in the journal.

Reflexive Journal

I found using the journal particularly helpful during analysis, a stage of the research that I found exciting but, at times, an all-absorbing and lengthy process.

In addition to monitoring my reactions and experiences, the journal helped me clarify my thinking, record progress, and became a self-care practice.

Reflexive Conversations

McCleod (2015) suggests that engaging “in conversations with colleagues about what comes up” can be conducive to increasing the breadth of our reflexivity. I had the

opportunity to discuss my research with peers, met with my supervisor regularly and engaged with personal therapy throughout.

Reflexive Interview

Before data collection, I worked through and recorded the interview schedule answering the questions as I thought a participant might. Whilst, IPA does not look to bracket off personal experience in the way that transcendental phenomenology does through the Epoché, there is still a need for a researcher to identify their assumptions to attain transparency and increase validity (Peoples, 2020). Having worked at anonymisedchunkoftext for nearly two years, I had become familiar with some of the discourse and narratives surrounding EE, food and obesity; the exercise increased my awareness of the situated knowledge I was bringing to the research.

Chapter 3: Analysis

"It takes tremendous energy to keep functioning while carrying the memory of terror, and the shame of utter weakness and vulnerability" - Bessel van der Kolk.

The analysis presented in this chapter, and discussed further in chapter four, comprises my interpretations of participants' interpretive understandings of their experiential reality. The chapter begins by briefly introducing the overarching and superordinate themes as derived through interpretive phenomenological analysis. These and associated subordinate themes are then presented in turn. A summary of findings is outlined in section 3.7, and a graphical representation of how the themes interrelate provided at the chapters close.

Verbatim extracts from the interview transcripts are included to illustrate the analysis and keep participants voices central. A master table exemplifying extracts across participants for each superordinate and subordinate theme is included in Appendix U.

All identifying information regarding the participants has been changed, and pseudonyms are used throughout.

3.1 Overview

The overarching theme representing the lived experience of emotional eating (EE) among participants is **"a 'deep-rooted' and 'powerful' response to intense emotions."** This overarching theme encapsulates the following four interlinked superordinate themes relating to participant lived experience:

1. **A *spectrum* of *awareness* of dynamic emotions**
2. **The 'stuck' self is experienced within shame fuelled cycles**
3. **A compelling coping mechanism**
4. **An entrenched and frequently misunderstood phenomenon**

3.2 Overarching Theme: A ‘deep rooted' and ‘powerful’ response to intense emotion

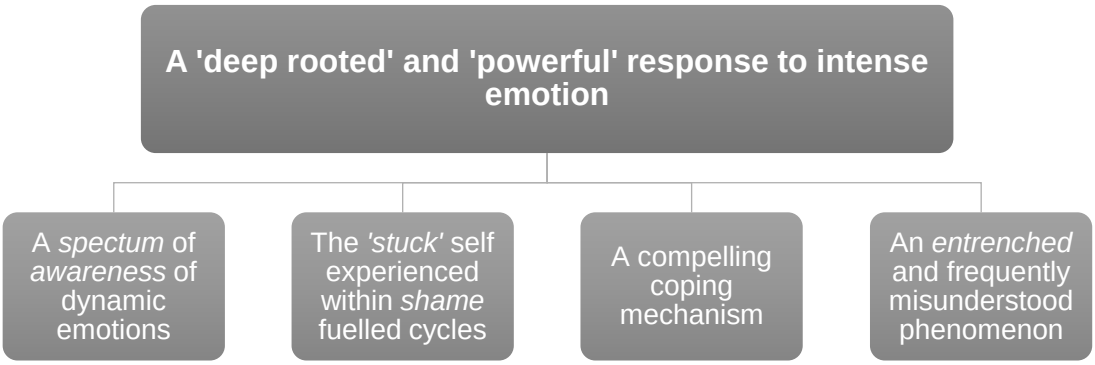

Figure 3.1. Representation of the overarching and superordinate themes

The overarching theme ‘a deep-rooted and powerful response to intense emotion’ illustrates that EE is a serious and forceful part of participants lives. It was important to participants that their experience of EE be captured as “more than comfort eating” (Tish-2/6), and I hope the overarching and superordinate themes reflect this.

Ideas relating to power weaved through participants accounts of their experiences. EE was spoken of as having the power to substitute emotions, stop thought, navigate depression, bring escape, ‘cope’ with the effects of horrific childhood abuse and complex trauma, bring sleep and transcend bodily awareness.

The emotions participants respond to by eating vary, but for all are intense and overwhelming. All examples of EE shared by participants related to negative emotions.

3.3 Superordinate Theme A: A *spectrum* of *awareness* of dynamic emotions

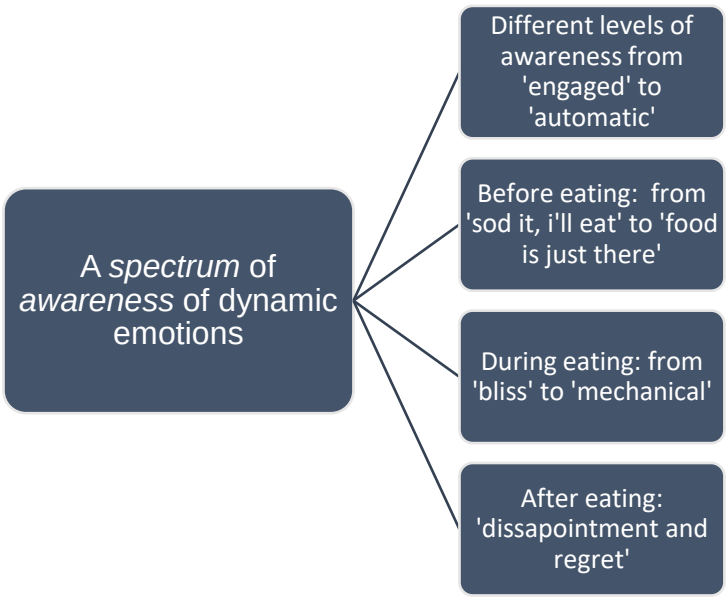

Figure. 3.2. Representation of superordinate theme A and associated subordinate themes.

The first superordinate theme, 'a spectrum of *awareness* of *dynamic* emotions', focuses on the raw experience of EE. Participants described EE as a transient process where emotions and awareness of emotions are in flux. There seemed to be a stark contrast between descriptions while 'aware' of eating and when it was experienced as a more 'automatic' process. I have interpreted this variety as falling along a spectrum, with 'engaged' eating at one end and 'automatic' eating at the other (discussed in section 3.3.1).

The subordinate themes outlined in sections 3.3.2-3.3.4 each represent a discrete temporal stage of the experience of EE. When *'consciously engaged'* in eating, participants describe a marked shifting of emotions during each stage of the process. When eating has felt more 'automatic', the participants spoke of being less aware (if at all) of their emotions. However, when eating stops, there is still a perceptible shift

into feelings of disappointment and regret regardless of engagement reported throughout the rest of the process.

3.3.1 Different levels of awareness from 'engaged' to 'automatic'

David overtly stated at the start of his interview that he considers the term ‘emotional eating’ to encompass more than one experience:

> *“so I have experienced what I would say is different types of emotional eating”*
>
> *(David-1/20-21)*

David differentiated between these ‘types’ with reference to his level of awareness before and or during eating; labelling one type “the unconscious one” (David-4/3) or “automatic eating” (David-14/31) and referring to the other as “eating to make myself feel better” (David-3/18). With the latter, David described being fully engaged throughout the process of eating, from deciding to eat, choosing food, eating, and reflecting on the process afterwards.

Conscious or Engaged Eating

With this experience of eating, a sentient choice is made to eat chocolate in response to feeling low, accompanied by unwavering confidence that eating will elevate mood. In the extract below, David implies eating the chocolate will be a private experience and decides he will eat the ‘whole bar’ ahead of starting to eat:

> *“the other type when you’re just sat there thinking ‘I know that I’m feeling really low at the moment, I’m going to get some chocolate, and I’m going to eat a whole bar of chocolate by myself because I know it’s going to make me feel better’”*
>
> *(David-3/15-19)*

During this form of eating, participants spoke of being fully aware of why they have decided to eat and subsequently have intentional and engaged interaction with the food. Eating is described as an active and sensual process:

"you break it up into individual cubes, and you're savouring every single, you know, everything; the taste of the chocolate bars."

(David-5/4-6)

Automatic Eating

The more 'automatic' process is, by contrast, much more perfunctory. Participants described only a vague awareness (if any) of the decision to eat. David explained that "it's just mechanical" (David-4/30), connotating a robotic and passive experience. Interestingly, David also commented that sometimes he finds 'conscious emotional eating' shifts into less aware 'automatic eating.' In these instances, food becomes inanimate and *"just something that's in front of me" (David-1/21).*

The extract below illustrates the qualities of the more 'automatic eating.' David does not recall initially sitting next to the table of food or deciding to eat, and he repeats the word 'picking,' evoking the automated feel of the experience. Unlike in examples of 'conscious emotional eating', no descriptive details about the food consumed are recalled:

"I've got times when we've had a family get together, and we've put a range of food out, and I didn't realise that I've sat next to it and that I've been picking and picking and picking. I've probably eaten half of what was on that table on my own, and that was for eight of us."

(David-2/14)

The assertion that eating can be a prosaic process where food is '*just* there' and '*just* eaten' was raised by other participants. In the extract below, Nicole describes an experience of EE involving little realisation of fullness. Interestingly, she remarks that there are times when she has an overall sense of 'not feeling good' but cannot pinpoint the exact emotions involved. Nicole also highlighted that the process of EE is distinct from mealtime eating:

"when I get down...or feel depressed or sometimes when I don't even realise what it is, but I'm not feeling good, and the food is just there, and I just eat and eat…you eat, and it's not like a meal, it's junk food […] erm… that's just there, and you just eat…you don't even register that your full."

(Nicole-3/13-18).

Like David, Todd also considers there to be different types of EE; he described his EE initially occurring 'unconsciously' and over time, evolving into a 'conscious' process:

"I think to start with it wasn't a conscious thing I just found that I didn't notice until…in fact, it was Kim, my wife who noticed it that, er…when I got down or sad or I was having problems, I tended to eat."

(Todd-1/6-12)

3.3.2 Before Eating: from 'sod it, I'll eat' to 'food is just there'

In accounts where participants are more aware and engaged during eating, a point in time is remembered when participants made a conscious decision to eat. This decision is made with a resolute and certain belief that eating will 'make them feel better'; difficult emotions will be substituted for good:

"…so if I've been upset…how you are feeling at the time you just sort of look at it and go 'if I eat that, that's going to make me feel better.'"

(Ellaine-2/1-4)

There is a time ahead of eating during which triggering emotions intensify and become overwhelming. These emotions culminate in the decision to eat, as illustrated by Iris below. Having described reaching this point, Iris laughed; her laughter implied embarrassment, and I wondered if perhaps acknowledging the intensity of the moment in itself felt overwhelming:

"I'll think, 'sod it, I'll eat'… you know, that kind of thing because it's all too overwhelming (laughs)."

(Iris-24/17)

Participants described their thoughts immediately after deciding to eat to focus entirely on finding food, which can become a frantic, fast-paced time. Sometimes, however, preparing food is an important ritual. Tish explained:

> *"when I am in that space where I feel lonely or sad or erm...whatever it is …it's not just about eating, it's the ritual of thinking 'ok, what am I going to have to eat? what shall I do preparing it?'"*
>
> *(Tish-26/9-14)*

In giving examples of more 'automatic' EE, participants were generally vague about their experience before eating. David rather ambiguously spoke of being "probably stressed out slightly" before eating at the family event, referred to in section 3.3.1 where David did not realise he had sat next to food. This *detached emotion* and lack of awareness gave the impression of a dissociative experience:

> *"I've not been aware that I've been eating. Beforehand, probably stressed out slightly […] worried about how it's all going to go"*
>
> *(David-2/25-28)*

Similarly, Ellaine gave an example where she *"found"* herself *"on the hunt for something" (Ellaine-9/11-12);* this suggests that she was not aware of choosing to eat, and the use of the word 'hunt' connotates that searching for food may feel primal.

Any bodily experience described before eating tended to relate to energy levels dropping due to the triggering emotional intensity. Iris, Tish and Nicole all referred to feeling 'exhausted' before EE, and David stated needing a "pick me up" *(David-19/1)* when his energy is low from depression. No participant reported feelings of hunger before they emotionally eat, although some described a sensation of physical 'emptiness':

> *"I feel empty, but not hunger, and I think hunger and emptiness is two different things…"*
>
> *(Todd-5/15-16)*

3.3.3 Eating: from ‘bliss’ to ‘mechanical’

Following a choice to eat and food being ‘found’ or ‘prepared’ in the ‘consciously engaged’ type of eating, participants described their emotions shift as they begin to eat. David describes this much anticipated moment as *“that spike” (David-25/25)*. Other participants spoke of feeling relief. Iris remarked that she feels calm and reassured, which contrasts significantly with the tumultuous feelings experienced in the period leading up to eating:

> *“this feels… satisfying, I feel happy, you know, everything is okay now, I feel calm…a lot of it is feeling calm for me, but again, it’s…all those raging emotions and it’s just…suddenly, you can go ‘aah.’”*
>
> *(Iris-19/4-7)*

Several participants raised the importance of EE being a sensual experience. Iris emphasised tactility as imperative and spoke in a way that suggests she becomes grounded to the moment as she begins to eat, allowing her to experience ‘bliss’.

> *“the chocolate has to be cloying in my mouth… there is something about the sensation of it sticking to the roof of my mouth and the way the chocolate melts, the texture of it that is really important, and in that moment that I’m actually putting it in my mouth […] the overwhelming feeling is this is blissful.”*
>
> *(Iris-18/30-19/2)*

Strong tastes are important to David. David described an example of the ‘automatic’ type of EE he experiences and explained that at the end of eating:

> “it’s almost like ash in your mouth.”
>
> *(David-10/25)*

This image of ash contrasts with the extract below where David describes his mouth as ‘feeling alive’ during consciously ‘engaged’ eating and is particularly distinctive in comparison. David has the awareness to enjoy the sensuality of the experience. The

extract also demonstrates how EE can bring vibrancy, happiness, and excitement, along with the significant realisation that experiencing 'joy' is possible. David spoke vivaciously and with energy as he described eating a new favourite sandwich:

> *"It's wonderful because you eat it, and you've got the sweet and you've got the sour, you've got bitter, and you've got the… and all of these tastes at once, and you're like 'woo,' and like your mouth is alive and you're like this 'wow, that's really, and it's like […] it's just the best […] you know, your tongue feels alive, you feel joy, you know you actually can do."*
>
> *(David-25/9-14)*

Regardless of awareness and engagement during eating, participant thoughts were reported to stop after taking the initial bites of food until nearing the end of eating. Whilst thoughts stop, a sense of escape can be experienced. David explained that:

> *"the feeling of eating actually removes away my ability to think or deal with anything, and I'll sit down, and I'll eat, and I'll forget about the world around me, and I'll just concentrate on the physical motion of eating"*
>
> *(David-1/12)*

In addition to thoughts stopping, bodily awareness can likewise cease or become selective during EE for several participants. Iris explained:

> *"it's like for that moment in time, the only thing that exists is was happening in my mouth. The rest of my body, everything, is like, gone."*
>
> *(Iris-20/2-4)*

3.3.4 After eating: disappointment and regret

All participants stated they feel unhappy after emotionally eating regardless of whether they made a conscious decision to eat or not. Feelings of shame can follow guilt, disappointment and regret experienced after EE and lead to the continuation of the EE cycle (discussed further in section 3.4.2).

Most participants spoke of psychological and physical discomfort that included feeling bloated and sick post EE, especially if they had overeaten. Ellaine describes her body as sometimes feeling 'wishy-washy,' implying weakness after eating. In retrospect, she will often analyse what she has eaten and why through angry self-questioning, which prompts regret.

> *"…sometimes I feel erm sort of full and 'wishy-washy' after I've eaten [...] a lot of the time I tend to feel sort of sick and think 'yeah, I shouldn't have eaten that' and afterwards I think 'what the hell have I just done? what have I done that for?'"*
>
> *(Ellaine-5/13-18)*

After EE, self-directed anger was also alluded to by David, who describes *"kicking himself" (David-3/22)* once he stops. Nicole gave an example of EE, which she chastised herself for afterwards and described as 'weakness.' This is a stark contrast to temporal moments of joy described by Iris and David in the previous section:

> *"and I…bollocked myself for doing it. It was a moment of weakness."*
>
> *(Nicole-8/21-22)*

David explained that he sometimes bombards himself with a string of accusatory questions after eating. These types of questions are characteristic of David's 'inner bully' that will be described in section 3.4.1. David's repeated use of the word 'question' emphasises the relentlessness of his regret:

> *"'Why did I eat that? What was the point? Were you really hungry then? Did you really need the energy…? Did it really give you energy? You know, and you are just sat there with question and question and question."*
>
> *(David-3/25-4/1)*

Tish spoke of often feeling disappointed with herself following EE and implied that a sense of defeatism accompanies this. The mindset that Tish described developing is characteristic of the type described as contributing to 'the obesity spiral' discussed in

section 3.4.4. Thoughts become focussed on the health and practical limitations of being obese, and emotions shift into hopelessness regarding future weight loss:

> *"…like I've let myself down in some way and that I'm never going to be the kind of healthy weight that I'd want to be. I'm not talking about being a fashionable weight but just a healthy weight. […] I would like to have more mobility and not be in pain in my joints, and the arthritis in my knee can be really painful sometimes… just all of those things that are solely attributed to my weight."*
>
> *(Tish-21/15-22)*

After EE, Iris similarly has thoughts that change is not possible, *"especially when you get to my age"* (Iris-21/7-8). Iris explained that she also usually wants to sleep afterwards; sleep perhaps becomes an adjunct to the escapism experienced whilst eating. She also commented on the divergence of her emotions from those experienced while eating. The juxtaposition of Iris swearing so soon after she recollected experiencing 'bliss' emphasises she soon finds herself in a very different emotional state:

> *"Immediately afterwards, I usually want to sleep. So, it's usually a feeling of this…you know, as I say, I have this absolute bliss the moment it's in my mouth. When it's gone, I think…there is a sense of 'oh shit, I've done it again'"*
>
> *(Iris-20/28-32)*

Todd also spoke about feeling disappointed once he has finished eating. However, for Todd, this is disappointment in a different sense. Since having his bariatric surgery, he becomes physically full very quickly, and so the positive feelings associated with EE are now only experienced for a frustratingly short time:

> *"Sometimes if I've got something I really fancy and I get that full feeling very quickly... there's a little bit of anger there…er…or…I get quite upset sometimes and feel disappointment."*
>
> *(Todd-15/19-22)*

Participants reported that emotion(s) experienced before eating have usually shifted and been replaced with different feelings after they have finished EE. The replacement feelings are typically negative and regretful. However, these emotions may still be preferable to those that initially triggered the EE:

> *"however horrible guilt and shame is, it's more bearable to me than being angry."*
>
> *(Iris-10/18-19)*

Reflection on Iris's "guilt and shame":

I found the insightful statement made by Iris above powerful and illuminating. My own personal and professional experiences lead me to wholeheartedly agree with Iris that guilt and shame are indeed 'horrible'. I am aware of how much destruction they can cause and the vast amount of time that can be spent attempting to find a way forward from these smothering emotions. For Iris to find guilt and shame preferable to anger reveals how extreme, *intense* and *deep-rooted* experiencing anger is to her. It also exemplifies the *power* that EE holds in being able to displace emotion of this magnitude.

3.4 Superordinate Theme B: The ‘stuck’ self experienced within shame fuelled cycles

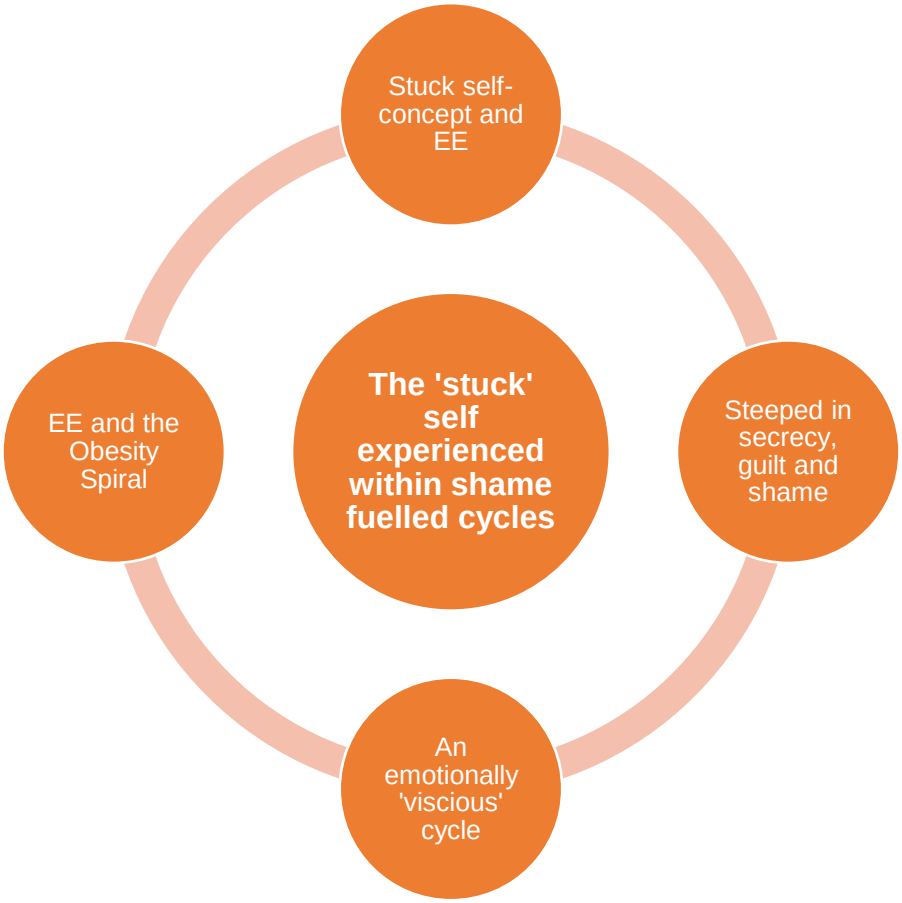

Figure 3.3 Superordinate theme B and associated subordinate themes

The second superordinate theme and associated subordinate themes are outlined in figure 3.3. This second theme broadens the experiential landscape under review by presenting how EE impacts the ‘self’.

Participants sometimes referred to experiencing themselves as ‘stuck’ in vicious cycles, circles, and spirals. Two of the subordinate themes represent this stasis regarding the EE cycle and a spiral of decreasing quality of life as living with obesity continues. Secrecy, guilt, and shame are discussed as a subordinate theme; these emotions also featured in the discourse surrounding participant's negative self-concepts and add fuel to the cycles and spirals outlined.

3.4.1 Stuck self-concept and EE

Most participants hold a negative self-concept often entwined with being obese and EE. For example, Ellaine regularly referred to herself as a *"fat cow" (Ellaine-12/1)* and seemed to attribute her current low self-esteem as being entirely a result of EE:

> *"…right now, there is nothing I really like about myself, and that's all down to food because of me eating the wrong types of food and just stuffing myself with it because I feel crap."*
>
> *(Ellaine-7/7-10).*

Iris labelled herself a *"failed bulimic" (Iris-23/29)* and spoke of how her EE challenges her sense of identity, leaving her feeling underserving and 'not a proper person':

> *"it definitely influences my belief about myself as a person…that I'm a failure, you know, not a proper person, as I don't deserve certain things, don't deserve nice things."*
>
> *(Iris 24/30-31)*

Tish has a positive self-concept in terms of having strength, but she used to find this difficult and confusing to reconcile with her EE and, in turn, would lead to her seeing herself as 'a failure':

> *"I am quite a strong person, and I could never figure out why I couldn't stop doing it, and I felt…you know…like a real failure."*
>
> *(Tish-1/28-30)*

Participants outlined times when EE occurred in response to specific aspects of themselves feeling under threat, e.g., David emotionally ate when a colleague left him his competency as a professional. It is imperative to Tish that she is not identified as a 'victim'; experiencing a neighbour as trying to victimise her led to EE. She explained that it felt like she was doing a 'nice' thing for herself by eating instead of being victimised:

"I'm being nice to me…when someone else is not being very nice…so it's like a way that I'm actually doing something nice to myself" – (Tish-9/12-14)

In listening to the participants discuss EE, I was struck sometimes by a childlike quality to their discourse. This impression may be resultant of the vulnerability they were showing through kindly sharing their stories with me. It also perhaps came from the examples of confectionary mentioned when examples of EE were given, e.g., *"those Willy Wonka type bars with the bits of jelly in it and the cracking, popping candy"* (David-5/6-7), *"sherbet dips and fountain"* (Nicole-6/16), and *"white chocolate buttons"* (Iris-24/6).

Interestingly, Iris overtly spoke of a 'childlike' component within her sense of self when EE. Openly referring to her 'toddler self' wanting to eat and describing another part of herself as the *"exhausted pretty hopeless mother*" (Iris-18/19). Iris powerfully illustrated how the time leading up to EE sometimes feels like a relentless and exhausting internal battle where the self is split:

"It's like being in the supermarket with a toddler who is too little to really understand, who wants whatever it is they want and is just having the most almighty tantrum about it… and you can't reason with them… and you've got two choices, either you stay the strong, capable parent who just lets them lay on the floor [...] and it's all terribly good [...] or what I actually feel like is that I've got this toddler having an almighty tantrum and I'm the exhausted rundown mother who just can't cope with it all, and I know that I'm going to give because I've done it… you know, every other time in the past. So why wouldn't I this time?"

(Iris-17/22-18/2)

Iris continues referring to the time before eating as a 'battle' and emphasised that the toddler 'comes to the fore' as eating begins. Iris's self-concept is negative at this moment. Her parent-self is described as "pretty hopeless" and toddler-self "recusant". Drawing on a self-concept moulded by multiple experiences of EE; Iris does not feel confident that she can 'look after' herself:

"there is this whole battle leading up to it as I say with this absolute recusant toddler and this exhausted, pretty hopeless mum who wants to look after her child but just can't and then at the point of giving in… I think the toddlers… comes to the fore […], of course; they will be really thrilled for those few minutes and then stuffing them in."

(Iris-18/17-24)

After eating, Iris is exhausted, and she describes not having had the "wherewithal" to have done anything other than EE, suggesting that Iris feels lacking in skills to emotionally regulate herself without eating. Iris describes wanting to sleep and escape into oblivion:

"…again I think it's almost like this absolutely weary mother that has given in to her toddler knows she has just done the wrong thing, knows this is not helpful, but just hasn't got the wherewithal to do anything else and just wants to lay down and go to sleep and go into oblivion."

(Iris-20/33-21/3)

Internal dialogue giving a glimpse of self-concept emerged in some participants' accounts. David often slipped into a stream of consciousness to explain his thought process and revealed the voice of a self-deprecating 'inner bully.' David is aware that he is '*a vicious bully*' *(David-24/19)* towards himself and gave an example of how his inner bully reprimands him after eating:

"it's then that it shifts and it's like 'oh he's eaten all the lollipops now' and 'oh he's eaten all his lollipops again, can't he just eat one, it's gotta be three or four hasn't it, and then the dialogue starts back up again."

(David 7/2-5)

3.4.2 The 'self' steeped in secrecy, guilt and shame

Participants portrayed EE as a shameful and guilt-ridden experience. Some told of times when shame steered their behaviour before eating began. Nicole explained how

she would minimise the chance of anyone knowing she had ordered takeaway food more than once in any given week:

> *"I used to buy a lot of takeaways…erm…especially when he was at work, but I would never order from the same take away in that week. So I had about four or five different takeaways just so they didn't know I was having more than one take away a week […] I used to go back to my emails to find out what takeaways I had used that week…so that I didn't go to one that I had already used because I would feel ashamed".*
>
> *(Nicole-6/4-13)*

Similarly, Iris recounted how she used to visit several shops to buy chocolate. Laughing slightly, Iris explained she would spend time thinking of fabricated reasons to justify her purchases. It felt awkward as Iris laughed, perhaps reflecting the sense of shame felt at the time in addition to her continued embarrassment in the present. This secrecy and fabrication, in turn, intensified her feelings of guilt and shame:

> *"so I'd stop on the way home… but I wouldn't stop at just one shop and get everything I wanted; I would stop at two, three, four shops because I'd be too embarrassed by everything I wanted and I would do these ridiculous things like… I mean (slight laugh) […] I would say 'I'll have a Mars bar and a Snickers, and I better get my husband a bounty and hang on… I better get…' and I'd go into this whole stupid rigmarole or say, you know, 'have you got…? What sweets have you got suitable for a child's party?...' it was all for me, of course."*
>
> *(Iris-25/26-32)*

David, Nicole, Iris, and Tish all spoke of 'hoarding' food. This hoard was described as comprising *"safety foods" (Iris-4/13)* and kept for future EE. In Nicole's case, the hoard is kept secret from her partner, bought separately from the main food shop, and mirrors behaviour earlier in life:

> *"I used to order my favourite sweets, which are sherbet fountains and double dips and hide them from Rich. I'd buy food separate from the supermarket*

food…it was the same when I was younger, I used to buy sweets and hide them from my sisters."

(Nicole-6/16-20)

The excerpt below exemplifies how secretive behaviour during EE can increase the shame surrounding it. Iris's choice of words included 'humiliation,' 'degradation' and 'disgust', providing a reminder of how damaging EE can be to the self-concept. A dichotomy within the experience is highlighted with Iris describing her shame as a more punitive facet of the phenomenon occurring alongside joy:

"So I go and get the chocolate buttons, now bear in mind that this is the middle of the night, nobody… it's only my husband and I living here… the children have left home, the dogs here, but…and I go and sit in the toilet to eat them, and it's like…(heavy sigh) that adds to the shame, it adds to the humiliation, it adds to the degradation. So, I'm…. kind of, giving in and yet punishing myself even more whilst I'm doing it because I'm thinking…. 'you are disgusting to sit in the toilet eating.'"

(Iris-18/31-19/5)

All participants prefer to EE alone, although also acknowledge secrecy can increase feelings of guilt. Some participants alluded to times when doing so places strain on their relationships. The embarrassed tone with which David told of removing 'evidence' and a change in his body language (shuffling uncomfortably in his chair and not making eye contact) brought connotations of EE feeling akin to an extramarital affair. David then referred to leaving the house to 'go and do that' which furthers this sense of disgrace and implies saying the word 'eat' at that moment is too shameful:

"I will go, and I will eat it all in the car before I get back home or park up somewhere, and I will eat deliberately, and I will eat through the chocolate bars and then go right 'rubbish in the bin', so there's no evidence of it when I go back home to my wife, even though she knows fully that the reason I left the house at that point is to go and <u>do that</u> (small sigh)."

(David-15/19-25)

3.4.3 An emotionally 'vicious' circle

In addition to reinforcing negative self-beliefs, shame was also cited as a key constituent in keeping participants stuck within a self-perpetuating EE cycle.

Nicole explained that shame can prompt further EE in the hope of feeling better. Nicole's excerpt below touchingly repeats that the 'better' she is seeking 'never comes'; the reiteration implies a sense of futility to the 'vicious circle' she describes. It is interesting to notice from Nicole's example that eating resumes in response to something someone has said (social threat as a trigger for EE will be discussed in section 3.5.3).

> *"and then as I had finished whatever it was that I was eating, I would feel shame […] which meant I would eat more until I would have nothing left and have to go to the shops just to buy some more junk food […] and then I'd see someone else, and they'd say something else, and then I would go home, and I would eat to make myself feel better again…but that feeling, it never comes…and then, I feel shameful because of what I did eat…it's just a vicious circle going around…erm, trying to make you feel better, but the feeling never comes back to feeling better"*
>
> *(Nicole-5/20-29)*

All participants gave similar accounts of experiencing themselves trapped within a cycle of EE and referred to self-directed anger and shame contributing to its continuation:

> *"but afterwards, I don't feel happy, I feel sort of mad at myself for doing it, but it's kind of a vicious circle…so I'm mad at myself, and so I find something else to eat…"*
>
> *(Ellaine-1/14-16)*

3.4.4 Emotional Eating and the obesity spiral

All participants connect their current difficulties with weight to their EE. Tish spoke about living with obesity impacting all areas of her life, and that for her, obesity and EE are inextricably linked:

> *"I think it affects every aspect of my life, actually, and I think for me they are probably entwined…emotional eating and obesity…I don't know if I can separate them in me, I'm not saying that other people can't, but I don't think I can separate them."*
>
> *(Tish-21/23-28)*

David explained the impasse he faces in understanding that his EE causes him weight gain alongside the power EE holds in allowing him 'to feel.' Through these being irreconcilable, David attributes a 'spiral' into obesity beginning:

> *"and then the weight carried on, and it's that limping between 'I know I should be eating healthy' to 'I know that I'm eating stuff that isn't healthy, but it's making me feel' and then it just…the spiral started"*
>
> *(David-22/29-23/1)*

Participants all alluded to their quality of life being compromised due to being obese. David explained he became increasingly overwhelmed, which led to more EE as his mobility decreased. Through David's repetition of the word 'snowball' in the excerpt below, a sense of obesity feeling a 'downward' spiral is accentuated:

> *"…the less physically fit and able I was, the more I hated the fact that I couldn't move around, I had to think about my movements […] I started thinking then and internalising and beating myself up for things and eating more [...], and it snowballed and snowballed and snowballed and snowballed and got worse and worse and worse…"*
>
> *(David-23/7-14)*

3.5 A Compelling Coping Mechanism

Figure 3.4 Superordinate theme C and associated subordinate themes

This third superordinate theme envelops how participants conceptualise their EE. All referred to EE as facilitating a way to cope with emotions that become overwhelming in their intensity. Again, illustrating how 'powerful' and 'deep-rooted' issues around EE can be, participants alluded to experiences of trauma and times of social disconnection and threat where emotions have become particularly intense, and they turned to EE to self-soothe. Participants also spoke about EE having addictive qualities. Iris, Tish, Nicole and David all implied that whilst they know it is detrimental to their health, they consider it a healthier and compelling coping strategy compared to other addictions.

3.5.1 Coping with Intense Emotion

Participants explained that a whole "gamut of emotions" (Iris-2/7) can become overwhelming. Iris conceptualises EE as serving to replace feelings that she finds too unbearable to acknowledge:

"so I guess a lot of when I eat is to do with replacing feelings that I can't bear to actually even acknowledge."

(Iris-10/15-17)

There are other times when Iris described eating as able to *"block emotion" (Iris-1/6).* Iris finds her anger particularly hard to tolerate. Iris moved from speaking about her mother (who had died two years previously) in the past tense to the present. This switch in tense indicates how anger still feels a real threat to Iris in the present.

"for me as a child being angry was dangerous; my mother was a psychopath umn, and I mean seriously, a psychopath. She was a very cruel and abusive woman, and if I got angry that would trigger, you know, that will trigger huge retribution from her; physical and emotional cruelty".

(Iris-9/2-6)

Both Tish and Iris referred to needing to 'watch' their emotions; their concern being that if they become too intense, fear and unsafety will follow:

"as I'm telling you this. I'm treading warily because if I let myself go too far down the road, I'd get really angry, and that frightens me"

(Iris-9/25-26).

"I had to really, erm, watch my feelings and emotions around that; a lot of difficult emotions came up"

(Tish-6/23-25)

Tish spoke of "eating on her feelings" (Tish-1/20) and "stuffing emotions" (Tish-5/28) and conceptualises emotions as either being 'taken in' by eating or 'projected' onto others. Tish gave a recent example of eating in response to emotions stirred by an aggressive neighbour. The vehemence of Tish's anger and wariness of emotions being projected rather than ingested is captured in her choice of the word 'vomit':

"he doesn't have the right to not be able to process his own emotions and come home from his brother's funeral and just vomit that almost at you"

(Tish-5/18-20)

David also construes EE as replacing emotions. When he has nagging doubts or guilt during eating, he reasons with himself that these concerns are exceeded by the benefit of feeling something different to before he started eating:

"you know that what you are doing is wrong, but you are just sat there thinking, 'but, I'm feeling something, and it's not...how I was, or I'm feeling, you know, a little bit better"

(David-5/22-25)

The intensity with which David experiences his emotions is underlined in the following extract. Here, David recounts a highly emotive incident with his daughter, who wanted to deliberately self-harm by cutting. David compares the emotions she expressed at the time to how he experiences EE:

"…we had a complete and utter meltdown, she was in floods of tears, and you know 'I hate myself, I can't feel anything' and wanting to cut herself so that she can feel pain and I'm sat there thinking, well, that's sort of what I do when I have stuffed myself with food."

(David-29/7-12)

While coping with intense emotions featured across participants accounts, there were examples when eating happened in response to an intense and unsettling sense of 'numbness':

"I think...those times; it's usually that I'm feeling quite down...and feeling quite numb...so I think 'ooo, I'll eat some of that because that will make me feel.'"

(Todd-4/28-2/6)

3.5.2 Coping with trauma and emotional abuse

All participants referenced occasions where emotional abuse had impacted EE. Five participants cited that EE provides a mechanism for coping with past trauma. Nicole and Todd intimated PTSD impact their EE in the present. David, Iris, and Tish frequently referred to adverse childhood events (ACEs) and had complex trauma presentations. In section 3.5.4, I will discuss David's experience of growing up with a mother dependent on alcohol. This section focuses on Iris and Tish's thoughts and experiences. Iris is in her sixties and Tish in her late fifties; both women suffered neglect, physical, sexual and emotional abuse as children. Both consider EE to have been a 'life-long' coping strategy.

Through beginning to process the dreadful events of her childhood, Tish has started to make sense of her EE:

> *"and with all the complex emotions that I have as a result of issues that happened in my childhood, it's not surprising, and I'm not as hard on myself these days"*
>
> *(Tish-2/10-13).*

Most participants referred to EE in terms suggesting they consider it a maladaptive means of coping, e.g.: *"it has been a coping mechanism, a very destructive and negative one"* - *(David-17/20-22).*

However, Tish conceptualises EE as a *healthy* coping strategy; particularly so for managing the impact of 'dark' events from the past:

> *"I think it is probably an incredibly healthy thing to do because I think it is what keeps me feeling ok about some actually quite dark stuff…and I think food has throughout my life helped me get through some really difficult traumas, particularly during my childhood […] I guess really I've done remarkably well to get to where I am…."*
>
> *(Tish-2/23-31)*

Tish spoke of how the abuse left her with feelings of loneliness, emptiness, and a sense of difference; she had no outlet at the time for expressing these emotions. Tish poignantly explained that it is in the loneliness surrounding abuse that food has provided comfort. Tish had earlier told me that she does not experience any feelings of *physical* emptiness before eating, making the contrasting description of *emotional* emptiness below particularly profound. The extract also demonstrates how enmeshed intense emotion in the present, past traumas, sense of self, and EE can become:

> *"I think when you've had the sorts of experiences that other people don't tend to have, that also makes you feel different…it makes you feel isolated, and it creates a feeling of loneliness within you that…erm…you can't actually share...I mean most of us can share things with somebody can't we? but no one can know exactly what something was like, and I think that's where the food becomes most comforting...in that loneliness...in that kind of emptiness and I think it's all inseparable…the trauma then and the emotional eating now."*
>
> *(Tish-23/5-15)*

Reflection on Tish's powerful meaning-making:

Tish's meaning-making in the extract above is one of the most powerful conceptualisations of EE and of surviving abuse that I have come across. As Tish spoke, I felt both moved and humbled and the reminder that 'no one can know exactly what something was like' struck a chord for me both as therapist and researcher. We cannot possibly know exactly what an experience has been like, but we can create space for a person's stories to be told and heard. Food has served both functions for most of Tish's life, and therein lies much of its hold.

Iris also considers EE to have been a *'survival strategy' (Iris-28/29).* Discussion around safety and protection came up several times during her interview. Iris emphasised that as a child, EE was the 'best' means available to her for finding comfort and protection:

> *"and you do it to protect yourself at the time, and at the time, you protect yourself in the best way that you can."*

(Iris-28/17)

Having food immediately available 'in case' she needs it and a private place to eat it in are important for Iris to feel safe. Emotionally eating in the toilet is a pattern that started in childhood and has associations with safety:

> *"I'd started to eat in the toilet when I was, you know, young and at home, and that was the only place that I could go in to, lock the door and know that nobody would come in."*
>
> *(Iris-18/8-10)*

As discussed, EE allows Iris to feel safe in the short term when facing her own or other people's anger. The longer-term impact of EE also serves a protective function. In being overweight, Iris feels that she is treated as a *"non-entity"* (Iris-30/22) by men and that this decreases the threat of being *"any kind of object of sexual desire" (Iris-31/24-25).* Iris lost a considerable amount of weight when she got married; however, a male colleague subsequently wolf-whistled at her and made inappropriate comments which triggered her to EE, and she regained weight; Iris explained, *"I went home, and I ate.." (Iris-31).*

Iris often finds herself conflicted between wanting to be healthier and wanting to retain feelings of embodied strength and decreased vulnerability that she feels come from the 'safety blanket' of being overweight. EE helps to knit together this 'safety blanket':

> *"It is a safety blanket for me and so a more powerful feeling, feeling more strong and less vulnerable but again I think it is about trying to experiment with a weight that is slightly more healthy but still, you know, I would probably never be happy to be tiny, I would feel too vulnerable."*
>
> *(Iris-32/14-22)*

3.5.3 Bridging social disconnect and or threat

All participants referred to occasions when perceived social disequilibrium prompted EE. Sometimes, this came from a social dispute or conflict, e.g., Tish's example of her aggressive neighbour. Other times, participants explained they worry about being thought of negatively by others, e.g., David and his work colleague.

Participants also gave examples of turning to food in the absence of social connection. Nicole recounted feeling very alone during lockdown whilst her partner was staying away for work, which led Nicole to EE for the first time in many months:

> *"I think I'd just got in a bit of a downie because it's just…he wasn't here and I was totally alone, and obviously I haven't, I hadn't seen my family for…well for months really...and I just thought I feel so low and alone."*
>
> *(Nicole, 1/5-8)*

I asked Nicole what she might advise a friend to do if they were in a similar situation and about to eat. Nicole's reply emphasised how relational connection is an important factor for reducing her EE, and accessing helplines can be a valuable resource for this:

> *"to speak to someone because I didn't know there was helplines out there for you to speak to people and there is, and I don't think it's out there enough for people to know [...] you need to speak to someone even if it's just the Samaritans right then…to just not eat because it's just not worth it in the end because once it's on, it's hard to get off…"*
>
> *(Nicole-7/31-8/8)*

Participants often became animated when discussing favoured foods (see, for example, David's description of eating in section 3.3.3). This livelier discourse contrasted in tone to accounts of the time leading up to EE. When discussing camaraderie with colleagues, David spoke with the same enthusiastic intonation, expression, and vibrancy as he did his favourite foods, conveying an impression that positive social connection can sometimes be on par to eating:

"I'm absolutely loving working at the place I'm in at the moment […] there is 14 of us, but it is constant duddeduddu (taps on desk), we are all talking on top of each other, there are ideas that are being thrown fast, there is a lot of silly and slightly immature behaviour, but it's very upbeat. It's very supportive."

(David-31/1-5)

David identified that he often emotionally eats in response to "social awkwardness" (David-28/12). In the following example, David felt concerned that he had upset a colleague; social self-doubt prompted his derogatory internal dialogue and eventually led him to EE.

The extract also illustrates other experiences characteristic of EE presented in this chapter. David is reprimanded by his 'internal bully' and shows a negative self-bias in presuming he has upset the colleague. This belief, alongside self-directed anger, intensifies as David's critical questioning continues. After telling himself to 'calm down,' he immediately begins to search for 'something' (implying food). The internal dialogue shifts from the voice of his 'inner bully' to that of someone more nurturing speaking to a young child, e.g., 'oh what's that….?', 'we've got a lollipop.' An active decision to then concentrate awareness on the lollipop is made:

"I've said something, and you've just seen someone…you know a little tiny flinch, and you just think 'Oh have I said something wrong there? Oh, why did she flinch'? 'Was there something wrong with what I've said? Was it really…you know…rude? Was it inappropriate? I don't think it was…' and then 'why did you say that for?' and 'for cripes sake, you've almost upset her?' […] and you sit there, and you just think…by the end of that time you're then really wound up, and you're angry at yourself, and you're thinking 'oh you're off aren't you,' and 'you've said something wrong' and 'why do you always do that'? And, you're just thinking… 'right calm down, let's find something, oh what's that? We've got a lollipop, let's get a lollipop, let's concentrate…'

(David-6/16-25)

EE as a response to a social threat or in place of social connection featured in most interviews. When asked if anything else might be helpful at the moment she decides to EE, Tish imagined an intimate relationship where she could feel loved and protected and stated this as being the only substitute for EE she can envisage:

> *"let's say I had a partner, for example, who you can be intimate with on that level...somebody who could really hold me and stroke my hair and…bend down and give me a kiss and just say, you know, I love you… he's not a nice person, and I'm going to look after you and somebody who would really make me feel protected and loved; maybe that could replace it…but I think it would have to be that powerful."*
>
> *(Tish-11/10-18)*

Food and EE have been stable constants throughout Tish's life and provided a substitute friend and confidante for many years. Tish anthropomorphises food by alluding to it as her 'best friend'; this reiterates the extent to which Tish considers food to be a comforter and accentuates how EE can bridge social disconnection:

> *"I think the most important thing for me, over everything that I've looked at about my eating is that food was my best friend for a very, very long while. When I was little, I didn't have anywhere to go with all my…with all of those feelings, but food…I probably would not have survived my childhood if it wasn't for food"*
>
> *(Tish-26/1-7)*

3.5.4 A strong drive comparable to addiction

Most participants either referred to addictions when discussing EE or categorically defined EE as an addiction per se. Todd stated he considers EE to be *"a very strong drive" (Todd-11/1-2);* Tish illustrated the compulsive nature of EE by comparing it to an itch, and Nicole spoke of EE being habitual:

> *"…it's like an urge. I suppose...a compulsion. It's like an itch that you have just got to scratch, and it doesn't go away usually unless you eat."*
>
> *(Tish-21/4-6)*

"a bad habit…like for some people it's smoking or gambling or drinking, and it's what I've got used to…eating when things have got to me, or people have put me down."

(Nicole-3/11-13)

Iris highlighted comparisons between the covert behaviour that she associates with her EE (e.g., shopping for food in different places) with the behaviour of 'addicts':

"I think that this whole thing of you know, like addicts… of kidding yourself, playing silly games, enabling it."

(Iris-26/26-29)

Interestingly, Ellaine and Tish noticed a significant increase in their EE when they gave up smoking. They also identified that they now emotionally eat in response to heightened emotions at times when previously they might have smoked:

"it will be seven years in August I gave up smoking, so I think, that's when I tend to turn to food instead of smoking, er, I go to that, whenever I seem to feel upset or stressed, I go to food."

(Ellaine-2/6-17)

"The weight really piled on when I stopped smoking (nodding head vehemently)…and I now definitely eat when I used to smoke, and I did actually smoke emotionally."

(Tish-18/28-29)

Tish expressively improvised how she may have responded to the incident with her aggressive neighbour if she still smoked. The rawness of Tish's feelings from the time seemed to resurface as she did so and exemplified the strength that both smoking and eating hold for Tish through her belief in their ability to 'dissipate emotion.':

"…all of that stuff that has gone on with my neighbour, I would have just had a packet of cigarettes and smoked all the anger away (imitates smoking) (laughs) (imitates blowing out smoke) (laughs)…
in a way, it would dissipate all of that emotion. Swearing and smoking and rrrmm rmmm rmmm"

(Tish-19/1-8)

Todd explained that he turns to either EE or to drinking alcohol when he is depressed. Before his bariatric surgery, Todd found eating more effective than drinking in bringing 'relief' and 'joy', with the only experience equalling EE for achieving emotional release being sexual intimacy. Most participants inferred that they considered EE to be less damaging than other types of addictions:

"in terms of using it in order to soothe myself…actually, erm well I suppose an alcoholic (laughs) that would be considered probably more unhealthy, I mean obviously it is some form of compulsion…an addiction"

(Tish-3/4-7)

David has difficult childhood memories of his mother drinking excessively and at a young age, resolved never to become an alcoholic:

"I'd be thinking no matter what, I am not going to end up like her, I'm not going to have this alcohol problem."

(David-30/22-23)

David remarked that "instead of going for the drink I've overeaten" (David-26/27) and conceptualises his EE as a way of avoiding alcoholism. This comparison is a particularly important part of how David makes sense of his EE, as shown by his further reiteration in the extract below that he 'desperately' did not want to become dependent on alcohol 'like my mum.' David spoke with an increased pace and repeatedly used the word 'addiction' as our conversation continued; he began to classify EE as an addiction in itself; categorising it alongside addictions of other family members and with his relationship to exercise:

"Sitting here talking about all of this today, I think all of my family have an addictive nature. When I used to run, when I used to do exercise, it was almost to an addictive level. My Mum drinking. My Dad, he's got… his addictions, my brothers got his addictions, and when I then went from rugby and not being able to play rugby, I think I then just moved my addictions to something else. I desperately didn't want to be an alcoholic, like my mum, so I found another addiction in eating. […] All I've done is just move from addiction to addiction to addiction, and so I think that the EE is partly that idea of wanting to feel better or change the way you feel, so it is a type of addiction…"

(David-37/15-20)

3.6 An entrenched and frequently misunderstood phenomenon

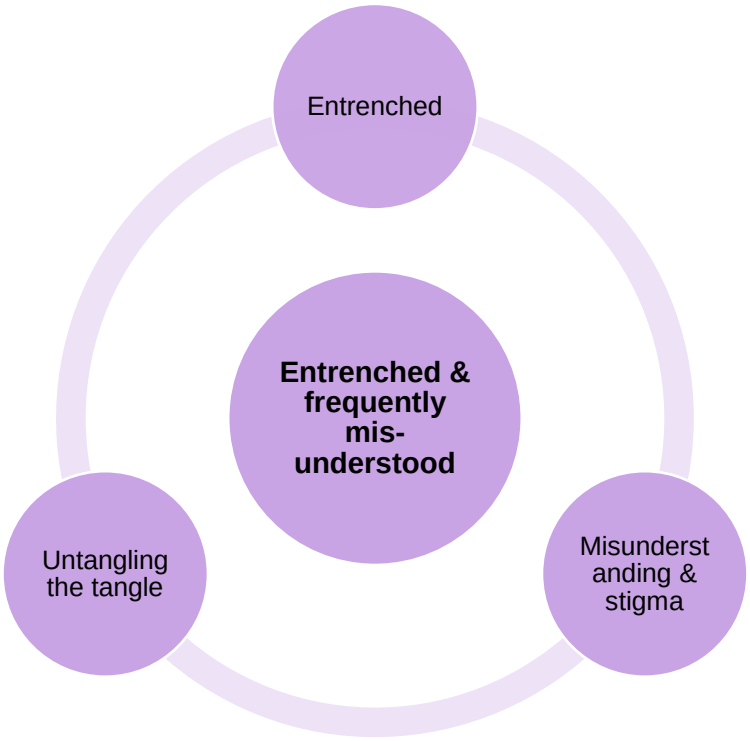

Figure 3.5 Superordinate theme C and associated subthemes

This final superordinate theme begins by re-focussing attention on the 'deep-rooted' nature of EE. When considering how EE can be 'entrenched', there is a natural overlap

with the earlier discussion of trauma. The theme seeks to emphasise that part of the power attributed to EE seems to come from it being a part of participant's lives for a long time, often since childhood. This entrenchment is particularly exemplified in accounts from Iris and Todd when speaking of their experience of EE post-bariatric surgery. In 3.6.2, emphasis shifts onto how participants are beginning to move forwards. Section 3.6.3 closes the analysis by presenting participants experiences of stigma and discrimination faced by participants, which they link to their EE.

3.6.1 EE is entrenched

Often participants connect the roots of their EE back to childhood. As discussed in section 3.5.2, some participants started to use food at an early age in response to systematic abuse, which started a lifelong 'love-hate' relationship with food. For Iris, EE became 'progressively worse' over the years, and her ambivalent feelings towards food became increasingly ingrained:

> *"…food is difficult, loaded, constant. I was eight or nine when I first started using food emotionally, I would say, and got progressively worse...what's my relationship with food? I love it and hate it, I suppose."*
>
> *(Iris-1/11-16)*

Iris's narrative illustrates the steadfastness of her EE. Trying to stop is not a new battle. She has endured many years of looking for an alternative coping strategy to no avail; making the prospect of change at times daunting:

> *"I just feel like I've battled my whole life trying to find an alternative way of dealing with these emotions, but, you know, how else do I cope with things?"*
>
> *(Iris 21/24-26)*

Todd did not begin emotionally eating until adulthood. He is unaware of exactly when it began but knows it was after he left working in the forces and experienced a

traumatic event; initially, it had been an 'unconscious process.' In the extract below, Todd recounts unhappy childhood mealtimes and wonders if they contributed to his later struggles with EE:

> *"…when I was very young, and I had a meal, you weren't allowed to get down from the table until you had finished, and I spent many hours sitting at the table with a cold dinner."*
>
> *(Todd-1/16-23)*

As an adult, Todd's EE experiences seem polar to his memories of being sat in front of a cold plate as a child. In the present day, he has control to actively seek out food that he enjoys (albeit limited post-surgery). As a child, he frequently had to remain passive, sitting in front of a plate of food that he had no desire to eat. Todd commented on this contrast:

> *"…being made to sit there when you don't like something […], and it tended to be a plate of cold potato I was sat in front of…I think it's different now because I'm not made to sit in front of the plate...it's something else driving me."*
>
> *(Todd-15/4-12)*

Tish explained that some of the power she attributes to EE is drawn from its longevity; EE has been a lifelong and sometimes sole means of nurture. It seemed important for Tish to acknowledge her strength of thought and feeling towards EE, explaining that she believes it was a part of her life pre-verbally:

> *"I think…and feel actually, it's not just a thought process…I have used food in that way my entire childhood…entire life…even back to before I was verbal and I think for that reason, I actually don't know whether there is something more powerful to me than food. I think there probably isn't"*

(Tish-10/28-11/4)

Notions of love and nurture seem an essential component of EE for Tish. Tish illustrated this in explaining how Turkish Delight reminds her of her late grandfather, a positive figure in an otherwise "difficult" childhood. She explained that eating Turkish Delight brings the following associations:

> *"the connection between the love that I'd felt for him and also obviously the loss of him…and I guess eating Turkish Delight as a child….it just made me feel good in those moments. Obviously, like eating that love."*
>
> *(Tish-27/3-7)*

Emotional eating after bariatric surgery

Todd and Iris both explained that whilst they are no longer physically able to eat to the point of feeling significant discomfort, the desire to EE remains. Iris remarked that she has been able to 'eat around' her gastric band and implied throughout her interview that the psychological pain behind why she is obese remained:

> *"it is certainly my experience that it is not a panacea because I still eat around bariatric surgery. So, if you are that much of an emotional eater, you won't stop."*
>
> *(Iris-35/25-28)*

Todd had been aware of the possibility of regaining weight following a gastric band and, for this reason, opted for a gastric by-pass. Often participants spoke of feeling an inevitability that they would emotionally eat. Todd explained that for this reason, he deliberately chose a procedure that made overeating potentially life-threatening:

"I didn't go for the band because I worked out that it's too easy to eat through…and I didn't want that...I wanted something with a definite…if you overeat, you might kill yourself."

(Todd-16/5-9)

Gastric by-pass surgery has meant that Todd has to be cautious about the food choices he makes, and often this leaves him frustrated at not being able to choose the high sugar foods that he would have previously:

"there are lots of things that I can't eat now; I can't eat stuff with lots of sugar in because I get ill, so I tend to eat more crisps and biscuits and stuff."

(Todd-3/20-24)

Todd continues to eat in response to depression. However, this now perpetuates his low mood and leaves him frustrated:

"there have been occasions when I have felt really down because I can't eat what I want to eat..."

(Todd-8/25-27)

3.6.2 Untangling the tangle

With EE being so entrenched, participants spoke of how conceiving a way forward can seem overwhelming. Iris described her eating as a "tangle" (Iris-26/2) that is difficult and confusing to understand:

"I confuse myself because I don't really know what it is; you know, I, it's weird, and it depends on the time of day, my mood…(long sigh)."

(Iris-24/23-24)

However, participants do hold hope. Most participants had experience of psychotherapeutic input that they had found helpful. Iris emphasised that gaining a personal understanding of why someone emotionally eats is important:

> *"I would say to anybody that does have an eating problem that 'there is a reason why you do it.' It's been helpful to unpick it in psychotherapy, I found out a lot about why I did it and looked at all the abuse, and everything that I went through that led to this."*
>
> *(Iris-28/10-14)*

Developing an understanding of psychological reasons underpinning EE can help break the cycles of guilt and shame discussed in section 3.4.1. Tish explained that understanding more about EE has been 'liberating' and has reduced some of the shame:

> *"I couldn't no matter how much I tried…trying different things; I just couldn't stop. Erm, and I used to think 'why don't I have the willpower?' because I have a lot of will power and of course it's not about willpower…but…so, when I felt I understood more about emotional eating as opposed to kind of 'comfort eating'…because they are slightly different aren't they?...um, it was actually quite liberating"*
>
> *(Tish-1/26-2/8)*

While Tish has found therapy over the years valuable, "*it's given me the quality of life that I've had…" (Tish/22-8),* she spoke of how she finds some strategies less helpful:

"I think there are lots of things that sound very valid about doing different things, if you know that your pattern is to eat a lot after dinner in the evening, then maybe go for a walk, but actually the reality of that doesn't really work, you know, the urge surfing is really good…I can actually, erm, manage that a bit…but I need to find…you know, things like they advise at the service which…it's all valid, don't get me wrong, it is all valid together, and it can work for a while, but I don't know, I just think there is something more."

(Tish-19/19-27)

For Nicole, looking out for patterns has been helpful. She would advocate using a 'food and mood' diary to a friend in a similar situation and cites it can help identify links between mood, circumstances, and eating:

"I would ask them to do a food diary to see when they eat and to write the diary because no one else is going to see it apart from themselves […] you can see where you eat erm…what the circumstances are as to why you overeat in that period and see the patterns with your mood."

(Nicole-4/25-29)

Iris mentioned not finding exercises that intend to encourage 'intuitive eating' helpful despite trying on many occasions. Her boredom and frustration at this evident:

"I've tried, you know in the past, I've tried all these eat slow, chew every mouthful 50 million times dah de dah de dah"

(Iris-19/10-11)

However, she has found some compassion-focused tools and meditations that encourage 'noticing' beneficial:

> *"I've learned a huge amount […] about trying to be compassionate to yourself, trying not to judge yourself, and it's been very helpful; she's done sort of guided meditations with me that have been really useful, just taking time to notice, step back and say, 'would you talk to a friend like that? then why are you talking to yourself like that?'"*
>
> *(Iris-27/25-21)*

3.6.3 Misunderstanding and Stigma

Participants expressed frustration that EE is often misunderstood, increasing the existing stigma surrounding obesity. Misunderstanding can come from friends, family, and professionals.

David compared ignorance surrounding EE with the lack of understanding he has encountered regarding depression. David commented that trying to explain the nature of EE to someone who does not experience it is frustrating and 'almost impossible':

> *"I think that's one of the hardest things to do...it's like trying to tell someone what it's like to suffer from depression because no matter what you tell them they'll most likely come up with some trite rubbish like 'come on, just get over it,' […] I think it's almost impossible to be able to explain it in a way that other people understand it."*
>
> *(David, 26/4-16)*

Ellaine shared a recent experience of trying to explain EE to a friend. Initially, the friend couldn't see a difference between Ellaine's EE and her own snacking on crisps. Elaine explained that the key difference lies in the motivation for eating and that it is a positive emotion she is seeking rather than food:

"(sighs)…it's really difficult, I mean I was trying to explain it to my friend at work the other day (sighs)[…] 'yeah' she said…but, I could go in the kitchen and eat a couple of packets of crisps, but I'm not saying that I'm an emotional eater' and I said 'well no, you've done it because you wanted a packet of crisps, I've done it because I wanted to feel happy, so that's why I start eating.'"

(Ellaine-9/3-14).

Interestingly, Ellaine found that her friend (who smokes) began to understand more when she compared EE to smoking.

David and Todd both raised that EE can sometimes cause strain within relationships. Todd is aware that *"it does get to her a bit when I do the EE…" (Todd-12/16)* and finds his partner frequently wants to discuss the issue. Occasionally, David's partner remarks on the money he has spent on food, *"and then sometimes she'll make a comment about… 'wasting money again'" (David–16/5-6).* These tensions highlight how there can be relational and practical implications to EE, where a greater understanding of the phenomenon would be helpful.

The stigma surrounding obesity is an ongoing struggle for many of the participants. Nicole spoke of difficulties she has had in finding work and suspects this is due to being discriminated against and stigmatised for being obese. Feelings of disappointment, judgment, and shame are then prompted, which serves to fuel her EE cycle:

"I've been in and out of work for a few years, and I think that hasn't helped. My CV is impressive, but when I go to the interviews…erm, I don't get jobs, and I feel it's because of my size and that makes me down, and then I eat again because of the fact that I didn't get the job that I wanted and it's just a circle really"

(Nicole –2/24-29)

Iris also finds that people judge her on first acquaintance and make a presumption that she is unintelligent. In Iris's experience, this type of prejudice is found among healthcare professionals. Speaking with conviction, Iris recounted a conversation with a bariatric surgeon:

> *"…we are so judged, I mean the first bariatric surgeon I saw said to me 'oh, you're very unusual because you're one of the few morbidly obese people I've seen that actually has above average intelligence' […] he then proceeded to tell me about how thick and ignorant most of his patients are who couldn't understand how to diet and have to have a band because it basically prevents them from eating"*
>
> *(Iris-23/1-8)*

Experiences such as this have led Iris to feel she needs to explain her EE and background of surviving child sexual abuse to professionals. However, she still finds EE and obesity are written off as 'self-inflicted' with little attempt among professionals to understand its underlying complexities. Iris explained working with a psychologist who is aware of the implications of what she has been through has been a refreshing experience. It seems pertinent how Iris adapts in the extract below the oft used analogy in mental health of 'not judging someone who has broken their leg' to refer to EE:

> *"I always feel like I have to tell doctors in order to get treatment for anything. I feel again, the judgement, you are not… I wouldn't say eligible…not deserving medical treatment even if it's for something that you may or may not have irrespective of your weight […] they just look at you like you're a nonperson and the way they say it, again it is as if you're stupid and as if you are causing it yourself…do they think that if somebody goes skiing and breaks a leg 'well they caused it, they went skiing.' At what point do you stop the judgement?"*
>
> *(Iris-36/5-14)*

3.7 Summary of findings

This chapter has considered the lived experience of EE among six participants who attend an NHS weight management/obesity service. Figure 3.6 provides a schematic summary of the findings. Interpretive Phenomenological Analysis has revealed EE to be experienced as enduring and complex; the overarching theme encapsulates this: A ‘deep rooted’ and ‘powerful’ response to intense emotions. Differing periods of awareness were referred to, including times of little awareness and times when participants fully engage with eating.

The overarching theme encapsulates four superordinate themes ‘a spectrum of awareness of dynamic emotions’, ‘the stuck self experienced within shame fuelled cycles and spirals’, ‘a compelling coping mechanism’ and ‘an entrenched and frequently misunderstood phenomenon.’ The superordinate themes include subordinate themes, each relating to different facets of the lived experience.

The analysis has shown that certainty, pleasure, despair, shame, joy and ritual can be found in EE. Participants tend to conceptualise EE as a coping mechanism that can diffuse difficult emotions, help manage the effects of trauma, bridge social disconnect and quieten social threat. Participants are very aware of EE’s potency, which was frequently likened to addiction and negatively impacts their sense of self. There can be misunderstanding and stigma surrounding EE, and people often feel stuck in vicious cycles.

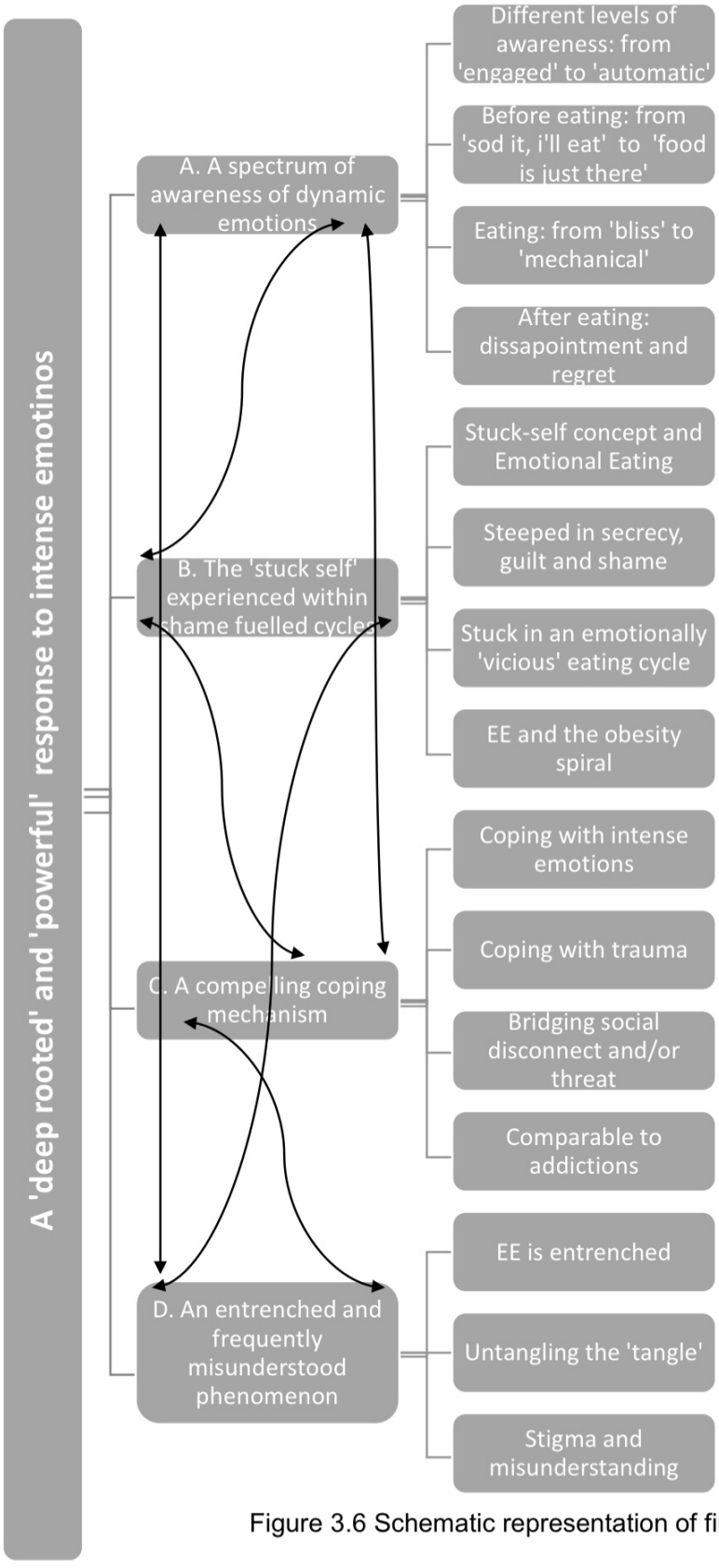

Figure 3.6 Schematic representation of findings

Chapter 4: Discussion

"shame is felt as an inner torment and sickness of the soul" - Silvan Tomkins

4.1 Introduction

The discussion that follows intends to extend the analysis by locating its findings in the context of the existing body of work on emotional eating (EE). I will begin by summarising the findings in relation to the research aims. Participant lived experience of EE is then discussed in light of key theory relating to conscious awareness, trauma, attachment, self-psychology and addiction. These are the academic areas that I consider to be most pertinent to the thematic findings. An evaluation of the research regarding its quality, rigour and limitations is then provided and includes statements on epistemological and personal reflexivity. Implications for further avenues of research and clinical practice are then considered ahead of conclusions.

4.2 Research aims and summary of findings

This study explored the lived experience of EE as described by people who access support from a specialist NHS obesity and weight management service. The research aimed to illuminate experiential reality and learn how participants conceptualise their EE.

Summary of the lived experience of emotional eating:

The lived experience of EE has been presented as a powerful, shame-driven process of highs and lows. EE provides a way to cope with intense and overwhelming emotions that can feel intolerable. Awareness of the experience whilst eating can vary. Participants described two extremes of EE, which are polar to each other, *'engaged'* and *'automatic'*. However, in-the-moment awareness can be and often is positioned between these poles. There are occasions when a deliberate and notable decision to eat is made, and if food is not readily available, a process of finding and or preparing

food begins. EE at these times is delineated by distinct changes in emotion before, during and after eating. Whilst participants attention is engaged (albeit to various degrees) with the sensual experience of eating, pleasant feelings including happiness, joy and bliss can be experienced replacing the negative emotion(s) that initiated the eating. On other occasions, some participants described experiencing a more automatic type of eating, during which food is 'just there' rather than a vibrant focus of attention. In these instances, eating is described as a less decisive activity. Instead, it becomes a mechanical action with little (if any) emotion experienced. After eating, an emotional shift occurs with feelings of disappointment, guilt and regret seeming to inevitably follow regardless of how consciously aware participants had been before and during the process of eating. There can be bodily discomfort after EE, particularly if a large quantity of food has been eaten, and thoughts become self-accusatory, critical and despondent. Guilt can turn quickly to shame and prompt the EE cycle to repeat. Participants can feel stuck within a process experienced as relentless with little space for self-concept to heal, develop and thrive. The accompanying feelings of embarrassment and shame can lead participants to eat in secret, which further perpetuates feelings of shame and isolation**.**

Summary of meanings ascribed to EE:

Participants consider EE as tightly intertwined and inseparable from their obesity. Therefore, EE is understood as a frustrating force behind what can become a 'snowballing' obesity spiral. EE is conceptualised as misunderstood, a behaviour that needs personal and professional understanding. Unfortunately, this can often seem lacking from people around them, including professionals. Frequent experiences of feeling misunderstood and stigmatised reduce self-confidence and further dent self-concept. All participants conceptualise EE to be a coping mechanism that defends against unbearably intense feelings. These feelings may relate to past traumatic experiences or other social threats to the 'self' and involve feelings of anger, loneliness and ostracisation. Participants make sense of EE by describing it as either comparable to an addiction or an addiction per se. EE was frequently understood as dating back to childhood experiences, including long-established feeding and eating behaviours. Difficult relational and traumatic experiences, including, in some cases, complex trauma, were also identified as relating to participants EE leading to the feeling that it is entrenched.

4.3 Discussion of analysis in context

The interpretive analysis of participant accounts of lived experience and their associated understanding of EE portrayed a complicated and multidimensional phenomenon. The analysis allowed discrete themes to emerge from the data. These thematic interpretations have helped capture experiential facets of EE and permit a response to the research question. However, the complexity that seems inherent in EE brings considerable overlap between the themes. The superordinate themes, therefore, should not be considered unconnected structures but interrelated and bidirectional. The extent to which participants describe an inextricable fusion between their EE and their obesity supports Buckroyd & Rother's (2008) assertion that a substantial subgroup of people living with obesity uses food to regulate affect.

4.3.1 Awareness of EE[2]

“all of these tastes at once, and you're like 'woo,' and like your mouth is alive” (David)

“and I don’t realise I’m doing it, and then I sort of come to a stop and think ‘how much have I just eaten….what on earth?’”(Ellaine)

Theories concerning consciousness and awareness have been debated for centuries and date back to Cartesian ideas of mind-body dualism, which positioned mental processes, i.e. consciousness, as distinct and separate from the physical body (Frith & Rees, 2017). EE would arguably not have been considered possible according to Descartes’ dualistic ontology.

Contemporary research in philosophy, psychology and neuroscience extends beyond binary constructions of subjective consciousness and objective physiology and seeks to evidence consciousness as a unified whole (Rose, 1999). Consciousness is now understood to include personal awareness of our physiological internal states and awareness of the external world around us (Rubin & McNeil, 1983). Theory particularly relevant to interoceptive and emotional awareness of EE and the ‘in the moment’ process as described by the participants will now be discussed.

Interoceptive Awareness

Interoceptive awareness has been described as a bodily monitoring phenomenon or internal self-scanner (Armstrong, 1968; Lycan, 1996, p. 72). In postulating the internal-external theory of obesity, Schachter et al. (1968) suggested that for people who have obesity, the internal state is “irrelevant to eating” (p. 97). Internal-external theories propose that some people have a reduced sense of interoceptive awareness, and therefore monitoring of hunger and satiety cues is dulled (Schachter et al., 1968). In such cases, people do not experience decreased appetite when stressed (Herman & Mack, 1975; Herman & Polivy, 1975; Schachter et al., 1968). Consequently, eating in

[2]Section 4.3.1 particularly relates to superordinate theme A ‘a spectrum of awareness of dynamic emotions’, and the subordinate themes ‘coping with intense emotion’ and ‘coping with trauma’ associated with theme C.

response to stressful emotions can become habitual, resulting in hunger signals becoming confused and people developing a reliance on external rather than internal cues to prompt eating (Bruch, 1973; Kaplan, 1972; Schachter, 1971). All participants alluded to occasions when they did not feel hunger before eating. Similarly, Iris, Tish and Nicole spoke of not noticing feeling full when emotionally eating, nor did Todd before having surgery. This lack of satiety recognition is consistent with reasoning that saiety signals also become desensitised with decreasing interoceptive awareness in frequent emotional eaters (van Strien & Ouwens, 2003).

An alternative suggestion for diminished interoceptive awareness of satiety relates to eating rate. Rolls (2005) suggests that consuming food fast does not allow sufficient time for satiety signals to be cued. Indeed, several participants remarked that sometimes they eat quickly when they emotionally eat, e.g. “and then it’s dadadadada (tapped on table), and it’s open a packet of crisps, eat the whole packet of crisps…” (David) and others also referred to ‘stuffing’ their food (Iris, Tish, Nicole and Ellaine).

The Roux-en-Y gastric bypass surgery has been successful for Todd in that he can only physically ingest a small amount of food and is now aware of when he is full (Wittgrove & Clark, 2000). However, whilst he is quickly replete physiologically, Todd explained that he stops eating because continuing to do so makes him physically unwell; however, the desire to eat remains and leaves him frustrated. Todd’s experiences of EE post-surgery highlight that awareness of external stimuli and internal satiety continue to involve complex interrelation (Rodin, 1981). It seems that the surgery, which has in effect restored interoceptive awareness (at least for satiety), has not resolved Todd’s wish to keep eating once full.

Wittgrove & Clark (2000) reviewed follow up data for over five hundred patients for whom they had performed Roux-en-Y gastric bypass surgery in the early years of the surgery being offered; weight records suggested an average excess weight loss of 80% in the first year. Crucially, following this review, emphasis was placed on the importance of psychological input during the immediate post-operative period, including a need for behaviour modification interventions. Such behavioural intervention could perhaps help patients pair their new, more pronounced interoceptive awareness of satiety with other emotional regulation strategies. Unfortunately,

however, post-bariatric surgery psychological intervention is documented in the literature as often limited, and patients such as Todd often need re-referral (Ratcliffe et al., 2014; Ristanto & Caltabiano, 2019).

Most participants described an absence of awareness of other bodily sensations accompanying EE, e.g. “it’s like for that moment in time the only thing that exists is was happening in my mouth. The rest of my body, everything, is like, gone” (Iris). This reduction in bodily awareness could also be due to a general decrease in interoceptive and or proprioceptive processing. However, escape theory provides the plausible psychological suggestion that focuses on the sensations and mechanics of eating attempts a separation from broader meanings attached to the self-concept that may have been coupled with the emotions experienced before deciding to eat (Baumeister, 1990; T. F. Heatherton & Baumeister, 1991). There are also times when people engage in eating to divert negative attention and associated emotion away from the body (Annesi & Mareno, 2015; Farrow & Tarrant, 2009); these too could be argued to be times of self-threat. Theory regarding dissociative experiences (Halvgaard, 2015a; Moulton et al., 2015; van der Kolk & Fisler, 1995) is also relevant here and discussed later in the chapter.

Emotional Awareness

Emotional awareness has been defined as the state within which people can access their emotional condition (Chalmers, 1997; Kanabra & Fukunaga, 2016). Participants spoke of feeling overwhelmed just before they consciously emotionally eat, instances of which happened either in response to an intense and identified emotion(s) (e.g.. anger) or sometimes in response to an *awareness of emotional intensity* caused by *unidentifiable emotion(s).* Ellaine shared an example that I will argue below is consistent with the former and Nicole an example of the latter. Difficulty sitting with the *intensity* of emotion(s) that occurs specifically due to a perceived ego threat is discussed in section 4.3.3.

It is proposed that eating following dietary restraint and EE can interrelate (Polivy & Herman, 1985; van Strien, 2018b), with restrained dieting purported to increase the likelihood of EE. Ellaine gave an account of eating in response to feeling disappointed

and “tipped over the edge” at gaining weight despite strict dieting (see appendix U), which may be an instance of restrained and EE interrelating.

When food intake decreases, our physiology has evolved to enter ‘starvation mode’ and adapts by slowing the metabolic rate and increasing hunger; this can create a strong feeling of deprivation and increases a person’s vulnerability to breaking their diet (van Strien, 2018b). Herman (1978) proposed that dieting for people living with obesity can become a stressor, leading to hyper-emotionality resultant from frustration and diminished ‘coping resources. Ellaine may have already experienced a degree of intense affect from the emotional (and arguably physiological and cognitive) stress of restricting and methodically recording her food intake. Such stress may have primed Ellaine’s emotional state, creating increased responsiveness to emotional change, feelings of deprivation and, therefore, further *intensified* the feelings of disappointment, frustration, and demotivation that she *identified* before eating.

Alexithymia is a phenomenon defined as “no words for emotions” (Sifneos, 1973); it is considered a typical trait of reduced emotional awareness (Kanabra & Fukunaga, 2016). There are often reports in the literature associating alexithymia with disordered eating (including EE) and to internal/external theories of obesity (e.g. Herbert et al., 2011; Lyvers et al., 2019; Pinaquy et al., 2003; Sifneos, 1973; van Strien & Ouwens, 2007). Alexithymia is also identified as showing a tendency to ‘act on’ rather than ‘verbally articulate’ feelings of emotional unrest (Pinaquy et al., 2003; Sifneos, 1996). Consistent with descriptions of alexithymia, Nicole has difficulty identifying emotions; she spoke of not knowing “what it is” but having an *awareness* that she is “not feeling good”. Finding herself unable to articulate or express her conscious awareness of intense but unidentifiable emotion, she emotionally eats. Although she cannot identify her specific emotional trigger, I consider Nicole’s subsequent eating a response to intense emotion because she reacts to her *awareness* of *an intense feeling* despite not being able to name it.

Awareness of the experiential process of emotionally eating

The analysis of participant lived experience suggests that awareness during the process of EE can vacillate. This finding is consistent with research by Grant (2008), which presented participants experiences of EE as including times of “consciousness

and intentionality" alternating with "times of unconscious eating" (p.131). Participant accounts in this current study included examples of being fully cognisant throughout the process of EE, times when retrospective descriptions detail a less conscious and more automated experience, and instances where awareness levels seem to adjust and reposition as eating proceeds. Whilst I discuss 'engaged' and 'automatic' EE separately, I propose that conceptualising these as two ends of a spectrum where awareness levels may shift (as do connected emotions) is more reflective of the overall experience of the process participants described.

Examples of participants' shifting awareness include descriptions of 'moments of realisation' after a period of 'automatic eating'. These temporal shifts are perhaps a type of phasic alertness (DeGutis & Van Vleet, 2010; Moruzzi & Magoun, 1949). Phasic alertness describes a quick change in attention following a salient event and can lead to self-orientation (Lin & Lu, 2016). These changes are suggested to serve as an 'attention filter' providing evolutionary advantage by allowing resources to be mobilised when most needed through selective attention (Aston-Jones & Cohen, 2005; DeGutis & Van Vleet, 2010; Lin & Lu, 2016).

Engaged Eating

The participants described occasions when their immediate awareness is fully engaged with the process of EE; this sometimes includes a hyper-focusing on the sensory and mechanical qualities of eating. There are occasions when conscious experience is recalled as present throughout the progressive stages of eating. Times of hyper-focus or particularly 'engaged eating' were often recalled in rich detail (see, for example, David and Iris's descriptions in chapter 3, section 3).

Theories of phenomenonl and access consciousness are numerous and rapidly evolving (Block, 2007; Drayson, 2015; Evans, 2009). I have found referring to Laureys' (2005) conceptualisation of consciousness a helpful lens for contemplating individuals awareness of EE; this considers consciousness to comprise of two main components, namely 'level' consciousness, i.e. *wakefulness* and 'content' consciousness, i.e. *awareness*. A healthy person who is meaningfully engaged in conversation is considered to be both awake and aware. Following this inference, a person who is consciously engaged and focused on eating is likewise both awake and consciously

aware. Conversely, someone who has no realisation of eating until they have stopped might be considered to have ‘level’ consciousness in that they are awake but have reduced ‘content’ consciousness or in other words less awareness.

Lycan (1996) describes basic awareness as a state of mind that has intentionality. The participants possess intentionality with the cognition that eating will help them to ‘feel better’ and consequently decide to eat. Intentionality continues whilst awareness shifts towards finding or preparing food and focus moves from the distress experienced at overwhelming internal emotions to the externality of finding food (van Strien, 2018b). David provided a germane example of this, with his stream of conscious thought capturing his sense of purpose and determination to redirect his awareness and concentrate: “right calm down, let’s find something, oh what’s that? We’ve got a lollipop, let’s get a lollipop, let’s concentrate’”.

All participants stated that their thoughts stop regardless of how consciously aware they are throughout eating (other than thoughts relating to eating), e.g. “I didn’t feel or think anything, erm, it just was, I was just eating” (Nicole), and David explained that instead of thinking, he “just” concentrates “on the physical motion of eating”. Heatherton and Baumeister (1991) might describe these experiences as operating at a low level of meaning where the ‘self is reduced to body, the experience is reduced to sensation, and action is reduced to muscle movement’ in a bid to decrease self-threatening thoughts (p. 88). In stark contrast to the examples of ‘automatic’ EE, participants seemed to place much importance on sensual experience; this sensory engagement is particularly illustrated in David’s description of eating a peanut butter, sauerkraut and grilled cheese sandwich (see chapter 3, section 3).

With more engaged EE, participants often gave examples where chocolate is the preferred food choice. Although colloquially, chocolate is attributed to mood-boosting properties, research has suggested that the enjoyment “spike” (David) in the early stage of eating chocolate is likely a greater contributor to positive associations than its neurochemical properties (Macht & Dettmer, 2006). The strong emphasis placed on taste and texture when participants are engaged with EE certainly presents as powerful. Iris explained the importance to her of chocolate's sensual properties; this sensuality seemed to help ground her to the moment (this example and grounding are discussed further in section 4.3.2):

> “chocolate has to be cloying in my mouth… there is something about the sensation of it sticking to the roof of my mouth”.

However, although there is a suggestion that sweetness and sensory cues such as fatty textures can enhance mood, the consensus currently in the literature argues that preference for sensory qualities in foods is most likely dependent on context and experience (Booth, 2008; Gibson, 2006). An anticipatory effect with people drawing on past enjoyable sensory experiences of eating chocolate is considered likely (Macht & Dettmer, 2006). The conviction with which the participants described beliefs that eating would improve their emotional state supports the idea that EE, in general, might be mediated by anticipatory effects in with memories of past *sensual experiences* are perhaps more readily accessible than the memories of negative *emotional* after-effects experienced after previous occasions of EE (Bohon et al., 2009; Macht & Dettmer, 2006).

Mindfulness is increasingly used as a strategy to help people manage their emotional eating (Mantzios & Wilson, 2015; Sogg et al., 2018; Yu et al., 2020). Mindfulness and mindful eating exercises serve to redirect focus from current emotional stresses and weight loss goals towards the experience of eating, thereby increasing awareness of internal cues rather than external signals to eat (Schnepper et al., 2019; Sogg et al., 2018; Warren et al., 2017). The practice intends to encourage non-judgemental awareness and seeks to accept and observe rather than change internal events (Egan & Fox, 2017; Sogg et al., 2018).

Automatic Eating

Most participants identified times when they ‘automatically’ emotionally eat and sometimes referred to these times as ‘unconscious eating’. This finding supports Grant & Boersma’s (2005) assertion that EE can sometimes operate below levels of consciousness and sometimes only becomes evident retrospectively. The example David gave of being unaware of sitting himself next to a table of food and not realising that he has been “picking and picking and picking” at a family gathering illustrates the disconnection between behaviour and awareness experienced at these times.

Considering this experience in light of Laureys' (2005) ideas on consciousness, David was experiencing wakefulness; however, the content component of his consciousness was perhaps diminished, leading to less awareness of eating. Until David's awareness shifts during a 'moment of realisation' of having eaten, his lack of awareness seemed fixed. Similarly, Christiansen et al. (2012) described "more or less subconscious" times when people may suddenly find themselves "snooping around in cupboards" (p.16) with no memory of deciding to look for food; this seemed to be the case for Ellaine when she finds herself "on the hunt".

Ellaine also gave an example of slipping from *conscious* or *engaged* eating into unconscious or *automatic* eating. Feeling self-conscious about her weight gain and the prospect of eating in front of friends had led her to not go to a barbecue with her husband and children; feeling ashamed and that she had "let everybody down", she consciously took one biscuit to "perk" herself up, she then became unaware of eating until she suddenly thought to herself "where has that half of packet gone?". The genuine surprise Ellaine recalled feeling at that moment complements Grant's (2008) assertion that automaticity perhaps contributes to EE 'being a difficult habit to break' (p.131). In this example, Ellaine initially had intentionality and full consciousness. Laureys' (2005) construct would describe her at full *level* conscious at the start of eating; as eating became more automated Ellaine's *content* consciousness decreased until a 'moment of realisation' at which point attention repositioned back, and she returned to being aware. The type of automaticity that Elaine described may have included an element of habit.

Kaplan and Kaplan (1957b) described eating in response to emotional conflict as becoming a *habitual drive*. A habit is considered to have formed when a behaviour that initially began as conscious and goal-directed becomes stimulus-driven and automatic through repetition and neuroplasticity, including in the sensorimotor striatum (Everitt & Robbins, 2005, 2016; Smith & Graybiel, 2016). Nicole (who alluded more to 'automatic' EE) referred to EE as a "bad habit" that she has "got used to like a smoker does".

Todd's account of how his EE developed seems to describe a converse trajectory to habit formation, describing it instead as beginning as an 'unconscious' process that became 'conscious' over time. However, other potential reasons might be that Todd

started to become more aware of EE once his wife had pointed the tendency out, or equally that following surgery, Todd's renewed interoceptive awareness has also led to a necessary increase in noticing his food intake (see chapter 3 section *3.1)*.

Dissociation perhaps also provides an important alternative mechanism mediating more 'automatic' EE in some people. The current *Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-V)* defines disassociation as:

> "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour" - (APA, 2013, p. 291)

There has been work suggesting an association between EE, dissociation and Binge Eating Disorder (BED) (see, for example, Palmisano et al., 2018). The literature shows little attention has been given regarding whether dissociation has a role in EE among people living with obesity who emotionally eat but *who do not meet the current diagnostic criteria for BED*. Perhaps more automatic eating may be considered overlapping with 'dissociative binging' at times, even in people who do not have a BED formal diagnosis. The instances of automaticity might be construed as a 'lack of control' that occurs within the automatic behaviour. However, times of automatic eating can occur when the amount of food consumed does not necessarily equate to "an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances" as per DSM-V diagnostic criteria for BED (APA, 2013, p. 353).

Halvgaard (2015) provides a rare example of dissociation being linked to EE in the absence of BED in a single case study (although it is noted the client had a previous history of an eating disorder and 'small but not big T trauma' (as defined by Shapiro, 2001). Halvgaard conceptualised EE as self-soothing for emotional distress that is not integrated into the mentalising processes of the prefrontal cortex and instead is expressed at a limbic level through somatoform dissociation (2015 p.189). Halvgaard (2015) worked with the client using EMDR over six weeks; outcome measures suggested the client felt more control over her affect overall, and her EE had decreased.

The way Tish spoke about eating sweet foods connotated dissociation as described in the definitions above. Tish explained:

> "sometimes when I'm eating, when I'm just eating lots of sweet stuff erm it...(long pause) is like I'm powerless, there but not there… I've forgotten what I was saying…sorry"

Reflection on Tish and Dissociation:

It may be that having listened to Tish bravely share her trauma history with me before this point in the interview predisposed me to interpret Tishs's experience as possibly dissociative. However, perhaps from the long pause when she spoke, and her momentarily forgetting her thoughts, the process of Tish recalling feeling "there but not there" seemed to parallel what she was describing. As she apologised for forgetting what she was saying, I also found myself unsure and a little vacant for a split second. There were other times during participant interviews when the thought 'is this dissociation?' crossed my mind, e.g., when David gave his account of automatic eating at the family gathering and Ellaine's description of feeling 'wishy washy', however this moment with Tish felt particularly intense.

A possible relationship between disordered eating and dissociation was recognised in 1907 when Janet set out his theory on dissociation. According to Van der Hart & Horst (1989), Janet's dissociation theory was based around nine main concepts, namely:

> "psychological automatism, consciousness, sub-consciousness, narrowed field of consciousness, dissociation, amnesia, suggestibility, fixed idea, and emotion" (p. 397).

Interestingly, all of the concepts Janet first described in his theory of dissociation have featured at times in considering how the participants can sometimes experience their awareness levels during EE.

4.3.2 EE in the context of trauma and attachment theory[3]

"…food was my best friend for a very, very long while. When I was little, I didn't have anywhere to go with all my…with all of those feelings, but food...."

(Tish)

All participants who disclosed their histories of trauma conceptualised their EE as a long-standing 'coping mechanism' for dealing with its impact. This finding is consistent with prior work that has established an association between adversity experienced in childhood and a tendency towards EE (e.g.. Ansari et al., 2018; Felitti, 1993; Strodl & Wylie, 2020). The design of the current study meant that causality could not be evaluated between frequent EE and trauma. However, the participants' powerful narrative provides persuasive evidence that for some people, the role trauma plays in the development and maintaining of EE must be acknowledged.

Emotions can feel dangerous

EE has served as a regulating mechanism for the participants for many years and, as Tish and Iris explained, has sometimes felt essential for 'survival'. The sense of EE facilitating survival parallels proponents of evolutionary and compassion-focused approaches, which position ongoing difficulties with self-regulation in response to a perceived threat as a product of our evolved threat-based affect regulation systems (Gilbert, 2014).

Iris and Tish explained their understanding of why they are prone to EE when angry with reference to their trauma histories; their cases demonstrate a learned response to threat that has been present since childhood (Birch & Davison, 2001; Johnson & O'Brien, 2013). As children, anger had been a terrifying emotion for both. Anger expressed by the adults around them signified danger was on its way. Showing their own anger was similarly dangerous and could, as Iris explained, "trigger huge retribution…physical and emotional cruelty". As adults, anger continues to feel enormously threatening. Both women articulated the belief that anger can be

[3] Section 4.3.2 is particularly relevant to superordinate theme C 'a compelling coping mechanism' and superordinate theme D 'an entrenched and frequently misunderstood phenomenon'. There is also overlap with the previous section on attention.

processed in two ways; it is either ingested or projected. For a very long time, taking anger in via food had felt the only way to ensure both psychological and physical survival.

Participant experience suggests that EE can sometimes abate anger allowing it to be privately internalised whilst maintaining a safe external environment. Eating quickly perhaps mirrors the intensity of the anger and the urgency of the flight and fight response; doing so in secret possibly increases this much-needed sense of safety and protection. Nicole and Iris also spoke of how they need to know food is available 'just in case', and so hide and hoard sweets. Iris also spoke about her tendency to hoard in general; this is interesting in light of work starting to explore associations between obesity, hoarding and disordered eating and implies a sense of safety is experienced when emotionally eating (Raines et al., 2015; Timpano et al., 2011). Eating to satisfy a basic need has indeed been identified as a function of EE, with the more basic the unmet need shown as increasing the likelihood of EE (Maslow, 1943; Timmerman & Acton, 2001). Safety is a fundamental human need, and contextualising Iris and Tish's experiences in this way lends support to suggestions regarding the involvement of threat-regulation systems in EE (Gilbert, 2013; Goss, 2011; Goss & Allan, 2010).

Existing research on associations between anger and EE is presented inconsistently in the literature. In the current study, all participants referred to times when they emotionally eat in response to anger, supporting studies that have previously associated anger with EE (e.g. Appelhans et al., 2011; Macht, 1999) but contradicting findings by Schneider et al. (2010) who found no anger associated eating for people living with obesity or healthy weight individuals. Schneider et al. (2010) did, however, find that trait anxiety may be associated. An alternative interpretation to the current studies finding, particularly given the participants' trauma histories, might be that it is the increased anxiety accompanying the fear of feeling angry that is prompting the EE; this would still fit with threat-system theories (Schore, 2002).

Emotional Abuse

An association between a tendency for disordered eating, including frequent EE and a history of suffering emotional abuse, is repeatedly reported in the literature (Hymowitz et al., 2017; Michopoulos et al., 2015; Palmisano et al., 2016; Strodl &

Wylie, 2020). Michopoulos et al. (2015) found EE the be more predicted by emotional abuse than other adverse childhood experiences. David referred to examples of his mother, whilst under the influence of alcohol being emotionally abusive towards him when he was a child and stated this had a long-term impact on him. Iris, Tish, Todd and Nicole also referred to having been subjected to emotional abuse in the past. Tish cited emotional abuse from her neighbour as having triggered her to emotionally eat in the present. Furthermore, most participants referred to times when they felt stigmatised either about their eating behaviour and or weight. Stigma in itself is a known trigger for emotional abuse; the participants' experiences highlight that both emotional abuse and stigmatisation can impact the EE cycle (Brochu et al., 2018; Home et al., 2001).

Sexual Abuse

The association between having survived a history of sexual abuse and living with obesity are well known in the field (Felitti, 2002; Gustafson & Sarwer, 2004; King et al., 1996; Noll et al., 2007). Findings can be mixed regarding associations between surviving sexual abuse and frequent EE (Palmisano et al., 2018a; Schmidt et al., 1997). However, Felitti's (1993) case-control study powerfully presents cases associated with childhood sexual abuse (CSA), where individuals identify eating to cope with trauma associated emotional distress. For the two participants, who frequently referred to their surviving CSA, its association to their EE has been incontrovertible.

Schiffer (1978) described people living in the wake of trauma as "living in a present that is filled with the horrors of the past that have become projected onto the future" (p.48). Iris and Tish both spoke of how EE serves a protective function in two ways, both of which align with Schiffer's depiction. Firstly, the women suggested they perceive EE as an action that they can take in the present to offer protection from emotional upset connected to the fear of reliving the past. For example, Tish referred to eating in response to her neighbour who triggered thoughts of a perpetrator from her past; she explained that eating helped prevent her from feeling victimised and stopped her from intrusive memories evoked by that feeling. Secondly, both women spoke of how EE helps bring "safety and protection" (Tish) and reduces the fear of facing a repetition of the abuse in the future. Iris gave an example of being prompted

to emotionally eat when a male work colleague had whistled and made inappropriate comments towards her. Iris explain that she found the idea of being perceived in any way as an “object of sexual desire” intolerable, and whilst she wants to lose weight to improve her health, she would feel too “vulnerable” without carrying some excess weight. These examples are concurrent with Felitti’s assertion that eating and obesity can represent a “sexually protective device” (1993 p. 732).

Grounding and Dissociation

In section 4.3.1, I discussed participants’ descriptions of reduced awareness during more *automatic* EE that sounded analogous to dissociation. Research suggests dissociation in the context of unresolved trauma symptoms can be a regulatory response to intense and extreme emotions, including fear (Dalenberg et al., 2012); this is consistent with this study's findings that emphasise the intensity of emotion prompting eating.

Conversely, participants relayed occasions when they seemed more *engaged* with EE, which seemed reminiscent of the hyper-focus and absorption of psychological grounding (see Boon, 2011). Considering the apparent importance of sensual experience to the more ‘engaged’ type of EE (see section 4.3.1), perhaps these times of directing attention to engage entirely with the process might be more accurately described as a form of implicit psychological grounding occurring parallel to experiential avoidance. Conceptualising this more engaged EE as grounding would be in line with Halvgaard’s (2015a) suggestion that feelings of emptiness and diffuse emotionality associated with dissociation can temporarily be replaced by consuming food.

The Loneliness of Trauma

Tish’s powerful reflection on the loneliness that has ensued from the trauma she has lived through and the impact this has had on her EE echo Felitti’s observation that sometimes obesity serves as “a protective solution to problems that previously had never been discussed with anyone” (2002, p. 44). The thematic finding that presents EE as a bridge for feelings of social disconnection or isolation is particularly applicable here. Participants described experiencing a sense of loneliness associated with past trauma, feelings of difference, and not feeling understood. For many of the

participants, the only consistent comforter in this loneliness has been food. There are also times when EE itself can be a lonely experience which can further augment feelings of loneliness that trigger shame, thereby continue the EE cycle.

Whilst participants spoke positively of the care at the obesity and weight management service they currently attend; this research sadly confirms previous work highlighting weight prejudice, discrimination and reduced quality of care shown towards patients living with obesity across healthcare fields (Flint et al., 2017; Phelan et al., 2015; Rathbone et al., 2020; Wu & Berry, 2018). Participants relayed that they do not feel professionals understand the extent to which EE has become part of their ongoing mechanism for coping with the traumas they have endured. Iris sometimes feels drawn to disclose details of her history of sexual abuse to help professionals appreciate the gravity underpinning her EE. These disclosures usually occur when Iris is feeling judged and misunderstood.

Participants spoke of perceiving professionals as seeing them as 'lazy', 'unintelligent', and 'lacking in will-power'; this is consistent with other studies highlighting similar experiences (e.g. Brown, 2006; Huizinga et al., 2009; Poon & Tarrant, 2009). The current findings support BPS assertions that training and guidelines to help reduce the weight stigma inherent in health care across professionals is needed (BPS, 2019). The BPS has also emphasised that weight management services need to include an increased focus on trauma care (BPS, 2019). The participant experiences shared in the current study suggests this needs to include awareness across multi-disciplinary teams of the role trauma can play in precipitating and maintaining EE. Trauma will not be a contributory factor to the frequent EE of all people accessing weight management services. However, the development of evidence-based, trauma-sensitive interventions is urgently needed to ensure appropriate psychological care is available for the significant number of people it does.

Attachment Theory

It was clear from the analysis that participants located their EE as beginning in and or stemming from childhood; this contributed to the phenomenon seeming entrenched. Several participants experienced tumultuous relationships with their caregivers in childhood and implied they had not experienced a 'secure base' (Bowlby, 1969). For

example, David found his mother to be ambivalent “sometimes she’d be fine, and sometimes she’d be aggressive, and that was her”. Iris described her mother as “a psychopath”, and like Tish, suffered the effects of neglect and multiple abuse perpetrated by both parents.

The interviews conducted were not clinical, and no measures of attachment style was given to participants. However, the relationships with caregivers, eating behaviour and the relationships with food described by participants are suggestive of insecure attachment styles described by proponents of attachment theory (e.g. Ainsworth, 1985; Bowlby, 1995; Tasca & Balfour, 2014).

No participant conveyed confidence that they believe themselves able to tolerate distress without an external means to cope (i.e., EE) in the way that a person with a secure attachment style might (Mikulincer & Florian, 1995). Therefore, the current findings support previous work that has established associations between living with insecure attachment styles, obesity, and disordered eating, including EE (e.g. Cruz et al., 2015; De Paoli et al., 2017; Faber et al., 2018).

Wilkinson et al. (2018) found that people in anxious attachment styles are likely to emotionally eat and consider themselves less capable of regulating negative emotions without food and called for attachment anxiety to be explored and emotional regulation strategies used as interventional goals for individuals with attachment anxiety who EE. Hernandez-Hons & Woolley (2012) identified EE as ‘reminiscent of ambivalent attachment’ as a cluster theme from interviews with eight women who emotionally eat and described a ‘love-hate’ relationship with food. The current study participants described similar ambivalent feelings towards food and EE, e.g. “I love it and hate it, I suppose” (Iris). For Tish, however, food and EE are spoken of with affection; food is externalised as “a best friend”, and EE is described as a “healthy” and “helpful” means of coping.

It may be that Tish realised early in life, her caregivers were unavailable to nurture her, and she, therefore, needed to develop secondary strategies to find an alternative way to attain feelings of security. Goal-directed behaviour models and primary versus secondary strategies documented in the literature suggest this plausible (e.g. Gillath

et al., 2016). It is possible that in lieu of reliable primary caregivers, food can become internalised as a 'safe haven' (Bowlby, 1995). Additionally, Tish made a powerful and insightful connection between the loss of her grandfather when she was very young and their favourite treat, Turkish Delight. In the years that have followed, eating Turkish Delight has felt to Tish like she is 'eating that love'; this fits with theory that suggests a child may adopt behaviour to re-establish proximity to their lost attachment figure (Bowlby, 1980).

Mantilla et al. (2019) considered the idea that an individual's eating disorder can become akin to an attachment relationship. It was concluded that in at least some cases, attachment processes are involved in how people relate to their eating disorders, and the authors suggest that narrative therapy may be helpful in these instances. Hernandez-Hons & Woolley (2012) suggest that therapeutic intervention focusing on attachment issues, including family therapy, may also help EE.

Bowlby (1958) conceptualised internal working models (IWM's) as cognitive schemas stored in implicit-procedural memory comprising an individual's patterns of attachment and relationships across the life time. IWM's therein mould a mental representation of the 'self' and 'other' interacting (Bowlby, 1973; Lemma, 2015b). Therefore, attachment styles are inherently significant to our sense of self and the way we relate with all aspects of the world, including food.

4.3.3 EE and Sense of Self [4]

> "what I actually feel like is that I've got this toddler having an almighty tantrum and I'm the exhausted rundown mother who just can't cope with it all and I know that I'm going to give in and the child is going to give…because I've done it… you know, every other time in the past. So why wouldn't I this time?"
>
> - Iris

[4] Section 4.3.3 particularly relates to subordinate themes B "The 'stuck' self is experienced within shame-fuelled cycles" and D "An entrenched and frequently misunderstood phenomenon". Discussion on trauma and attachment also continues.

Applied psychologists are increasingly exploring understandings of 'the self' to help provide a framework for conceptualising psychological difficulties. Since eating disorders and obesity have previously been described as 'self' conditions (Bruch, 1973; Sadati et al., 2016), this section will attempt to briefly discuss how constructions of 'the self' presented by the participants may impact *on* and be impacted *by* their cycles of EE.

The construct of 'self' is generally considered to include cognitive knowledge and beliefs about who we are and how society sees us; it is conceptualised as a social system that is constantly evaluated through mentalisations of how we perceive others to view us (Burkitt, 2008; Schaffer, 2004). Self-esteem summarises how we feel about these beliefs, and consequently, our evaluation of our worth (Coopersmith, 1967; Johnson & O'Brien, 2013). Throughout the interviews, all participants inferred that they hold a negative sense of self indicated through low self-esteem. For example, Tish commented, "I'm certainly not the best version of myself"; Ellaine stated, "right now there is nothing I really like about myself'" and Iris shared that immediately after EE, her first thought is usually "I'm a failure, you know, not a proper person".

Similarly, participants often perceived that others view them negatively, which negatively impacts their own evaluations of self (Heatherton & Vohs, 2000). David explained that once he has finished EE, he often starts a negative dialogue with himself, using the perceived critical voice of the other, e.g., "oh, he's eaten all his lollipops again, can't he just eat one? It's gotta be three or four hasn't it'".

This negative sense of self tends to impact participants' estimation of self-efficacy (Bandura, 1977), making the prospect of change feel improbable. Todd sees himself as a 'hopeless case'; and reinforces this with his perception of how he believes therapists in previous services have experienced him "I've had therapists who've been in tears after an hour with me (laughs), that's how screwed up I am". Nicole does not feel she is ready to manage her affect yet without being in therapy, "someone always goes and says something that sets it off…so I don't feel quite ready to stand on my own two feet yet".

As discussed previously, emotional abuse is associated with disordered eating patterns in people living with obesity. Hymowitz et al. (2017) found an association between emotional abuse and obesity-related disordered eating mediated by poor self-prediction in a survey of undergraduates. The current study used a different methodology with a much smaller sample size and, therefore, does not replicate the Hymowitz et al. (2017) study. However, all participants indicated that their self-perception can be poor, have experienced emotional abuse and regularly emotionally eat (arguably a type of 'obesity-related disordered eating'), and so the current findings support Hymowitz et al., (2017) from the perspectives of patients attending an obesity and weight management service.

Internalised Parent-Self

Some theorists suggest that our internal working model includes representations of our 'internalised parents' that are particularly important for future relational development (Zimmermann, 2006). The internalised parent holds both our encounters with our parents/primary caregivers and our perceptions of these experiences; the 'internalised parent' representation can replicate in future relationships with the self and others (Jacobs, 2012).

David referred to his 'inner bully' several times during his interview. The bully tends to particularly present with a stream of self-deprecating thoughts and accusatory questions after David has emotionally eaten. This 'inner bully' may be conceptualised as David's internal critical voice incorporating an 'EE' voice akin to the internal 'eating disorder 'voice'' often described by people suffering from diagnosed eating disorders (Bruch, 1978; Pugh, 2016; Pugh et al., 2018). Later in the interview, David referred to occasions when his mother would question him about his weight using a stream of accusatory questions. The similarities between the voice of the 'bully' and David's memory of his mother's voice imply that David may have introjected a critical representation of his mother that he has also come to associate with his EE. David considers his 'inner bully' to be keeping him in a cycle of self-deprecation and EE.

Iris spoke of an internal battle between parent and child parts of herself, leading up to deciding to eat. This disintegration of self is consistent with Iris's childhood which

lacked the nurturing developmental environment essential for fostering psychological and physiological regulation systems (Kohut, 1977). For Iris, the self is split, and a struggle begins between herself as an 'exhausted rundown mother' and herself as a 'recusant toddler'. After EE, the parent self-returns defeated. It is noticeable how, at the end of EE, both Iris's parent part and child part need nurture.

Kohut (1977) put forward two types of 'self' disintegration; the 'fragmented self' and a 'depleted self'. Iris's 'toddler-self' appears to be an example of the former; the toddler has no confidence that her mother can establish a compassionate boundary and so fragments. Iris's "exhausted" and "defeated" parent-self can be argued as an example of Kohut's 'depleted self' (Kohut, 1977). After eating, Iris explains this part of herself "just wants to lay down and go to sleep and go into oblivion". Kohut conceived a 'depleted self' to have high levels of dissociation, withdrawal, excessive energy conservation and a lack of energy in the "brain/mind/body system to form the interconnections responsible for coherence" (Schore, 2002, p. 456) which Iris implies through the exhaustion she describes.

The healing of the 'disintegrated self' is often a key therapeutic aim when working with trauma survivors (Spiegel & Cardeña, 1991; van der Kolk & Fisler, 1995; Zepinic, 2016). Leach (1998) recommends transactional analysis (TA) to encourage integration for clients living with obesity. The therapist adopts a therapeutic role of both 'controlling parent' and 'nurturing parent' to model empathy and congruence to the client and encourage a nurtured sense of self to develop (Brunt, 2005; Leach, 1998).

Child-Self

Participants showed a tendency to choose confectionary usually associated with children when emotionally eating (see chapter 3.4.1). Some participants also connected EE to childhood in other ways, e.g., Iris fabricating buying food for a children's party and Nicole hiding from her partner the same sweets that she hid from her sisters as a child. The childlike food choices fit with previous studies that have shown a tendency towards high calorie, highly palatable foods when emotionally eating (e.g. Wallis & Hetherington, 2009; Zellner et al., 2006). However, it does also seem that participants often incorporate a childlike component to their EE schema,

perhaps attempting to create a space to allow their 'childlike self' expression denied in childhood.

Todd's tone of voice and the account he gave of childhood mealtimes (see chapter 3.6.1) suggest that his parents feeding style may have been authoritarian (Hughes et al., 2005b). In addition to being predictive of low self-esteem (Bun et al., 1988), authoritarian parenting styles are theorised by some to contribute to a child's decreased interoceptive awareness and a subsequent tendency for EE, particularly in boys (Birch et al., 1987; Strien & Bazelier, 2007). This mechanism would fit with Todd's eating profile before undergoing gastric bypass surgery.

Todd observed the contrast between feeling "excited" as an adult driven to find food and his younger self who would feel "angry" and "sad" when passively made to sit for as long as it took to clear his plate. It seems EE may at times have helped Todd to feel empowered around food in a way that had been missing from his sense of self as a child. It might be that Todd has incorporated a representation into his IWM of empowerment that he now associates with EE (Zimmermann, 2006). In the present day, there is a parallel with Todd's child-self; he once again does not have the autonomy to decide when he has finished eating, albeit that as an adult, the desire now is to continue eating past the point of satiety which impacts on his low mood. Todd's experience mirrors case studies that suggest an association between people with insecure attachment and emotional difficulties post-surgery (Magee-Burford, 2021). Todd's ongoing distress and his continuing to experience a 'drive' to emotionally eat supports calls for increased psychological therapy post-bariatric surgery (BPS, 2019; Ristanto & Caltabiano, 2019; Sheets et al., 2015). Sadly, Todd's experience also reinforces Iris's assertion that bariatric surgery "is not a panacea" for everyone.

Self in threat

Escape

An ego threat can be considered a threat to self-esteem (Hodges, 1968). As discussed, participants appeared to display generally low self-esteem and hold

negative self-concepts likely mediated by past life events that, for some, include complex trauma (Coopersmith, 1967; Epstein, 1973; Kahana et al., 1988).

Therefore, with self-esteem low, the participants are perhaps already particularly vulnerable to finding 'ego-threats' unendurable and predisposed to seek escape from the self (Dixon & Baumeister, 1991; Heatherton et al., 1991). The examples of more 'engaged' type eating present participants showing a determined intention to EE. This intentionality accords with escape theory, emphasising high motivation to escape self-awareness (Dixon & Baumeister, 1991; Duval & Wicklund, 1972). As predicted by Heatherton et al. (1991), participants experience an attentional shift away from the ego threat and onto the food; once they are eating, participants reported that their thoughts stop.

When participants reported emotionally eating in a more automated way, memories of the thought process during and preceding eating was absent or limited. However, although a motivated escape was not *consciously* overt, it is still possible that mechanisms to internally escape from or indeed preserve the self may be mediating the process. Whilst I cannot claim that participants are dissociating during instances that they describe as 'automatic' EE, they describe a dissociation-like experience. Mollon (2001) describes dissociation *"and related forms of detachment"* process as 'internal escape', the definition below seems pertinent in light of the trauma history of several participants:

> If childhood trauma or abuse is repeated, and if the abuser is a caregiver, so that the child has nowhere to run and no one to turn to, then internal escape is resorted to—the child learns to dissociate more easily and in a more organised way. In this way, the personality system preserves at least parts of itself from the impinging trauma or violation, by sequestering, or sealing off, the area of damage (p. 218).

Ideal Self

Rogers (1961) theorised that a person becomes conflicted when the self is in a state of incongruence, i.e., the 'real self' (how they currently experience themselves) is inconsistent with representations held of their 'ideal self'. When the 'real self' and 'ideal

self' are similar, then a person experiences a state of congruence; this encourages positive self-esteem and a positive self-concept (Mearns et al., 2013). A congruent 'real self' develops in empathetic environments where positive regard is given unconditionally (Rogers, 1961).

The participants' life histories imply that they have experienced a lack of unconditional positive regard and that this has likely contributed to low self-esteem, which, together with shame, contributes to a tendency to EE. Some participants hinted at how their ideal self might look, e.g., "socially-adjusted" (David), "a strong person" (Tish), "still a person" (Iris) and "listened to" (Nicole). Indeed, on several of the occasions when participants emotionally ate the 'ego threat' might be seen as an attack on the potentiality of the 'ideal self' in addition to augmenting feelings of despondency and incongruence felt in the current self (Heatherton et al., 1991; Rogers, 1961).

David described his current reality (i.e., his Rogerian 'real self') as "anxious" and "socially awkward" during his conversation with a colleague (see chapter 3.4.1). The anxiety David experienced whilst concerned that he had upset the colleague is incongruent to his ideal "socially adjusted" self (Hayes et al., 2016) and perhaps led him to seek experiential avoidance through eating. David explained that when he feels connected to his immediate family or enjoys camaraderie with colleagues, he does not think about food; then, he is perhaps closer to a congruent real self.

The self-discrepancy theory also considers the concept of 'ideal self' important (Higgins, 1987). Proponents argue that different types of accessibility discrepancies between the domains of the self and representations of 'self-state' (how the self is perceived) link to different emotional vulnerabilities. The self is considered to comprise of three basic domains, the 'actual' self (the attributes the individual and other believe they possess), the 'ideal' self (ideal to both the individual and other) and the 'ought' self (the attributes the individual and other believe the self should possess) (Higgins, 1987). A self-state representation is taken to consist of one domain of the self ('actual', 'ideal' or 'ought') and one perspective on the self ('own' or 'other). Self-discrepancy may be occurring in the examples participants gave of emotionally eating in response to threats relating to their careers, e.g., Nicole emotionally eats when she is not offered work that she is qualified for; David's EE increased after an injury ended his sporting career.

Some participants also implied that their sense of self has become enmeshed with their EE and associated experiences of living with obesity. Drawing on Merleau-Ponty's philosophy regarding the body as habitual, Christiansen et al. (2012) discuss how our routine behaviours can become experienced as intimate and connected parts of the self. It is likely that connecting the self with EE also connects the self to more shame. The remainder of this section will position shame as a key component of the participants' EE cycle.

Guilt and Shame

Shame appears central to perpetuating the EE cycles described by the participants. Guilt is differentiated from shame by focusing on an individual's disappointment at their own behaviour, whereas shame involves a judgement on the *entire self-system* (Lewis, 1971). Guilt can transform into shame when its evocation threatens the 'ideal' self of the individual and the mentalisation of the 'others' perception of them (Cunningham, 2020; Higgins, 1987). When experiencing shame, the whole self is considered flawed and, as Iris expressed, *"not a proper person".*

Iris's account of how guilt and shame are preferable to the fear she associates with anger emphasised the ferocity of the emotion she is seeking to avoid and flags that for Iris, guilt and shame are presented as an inevitable part of the experiential process of her EE. This inexorability of shame was also true of the other participants; all experienced disappointment and regret after eating, which seemed closely followed by feelings of guilt and subsequently shame. A sense of 'stuck-ness' came through in the analysis, and it seems plausible that the centricity of shame within cycles of EE solidifies this feeling of stasis.

From contextualising participants understandings and experiences of EE in the light of contemporary thinking on trauma, attachment and self-psychology, a shame driven formulation of their EE seems fitting. Steele et al. position shame firmly within the edifice of attachment:

> Shame is a response to (real or perceived) abandonment, rejection, or criticism, and is thus deeply embedded in the attachment system and attachment cry (2017, p. 400).

An attachment informed perspective on shame implies that participants may already have a primed sensitivity to shame; they are generally 'shame prone' (Johnson & O'Brien, 2013). There is a suggestion that the innate capacity to experience shame holds a social evolutionary advantage; however, when shame becomes chronic, it is debilitating to the self (Cândea & Szentágotai-Tătar, 2018; Gilbert, 2014; Johnson & O'Brien, 2013). Compassion and self-compassion are cited as an antidote to shame (Gilbert et al., 2014). A compassion-focused approach to reducing EE aims to cultivate inner compassion and evaluate threat, tolerate negative emotions and modulate emotional intensity (Gilbert, 2014; Goss, 2011). The lived experiences voiced in the current study suggest that an amalgamation of past and present shame is an integral and incitive component of the intensity experienced and can be conceptualised using a compassionate perspective on affect regulation as outlined below.

It is widely accepted that our bodies and brains have evolved mechanisms to help protect us from physical, psychological and social harm (Gilbert, 2014; Johnson & O'Brien, 2013; Schore, 2002). However, research has demonstrated individuals with difficult attachment histories have difficulties with right hemisphere processes for self-regulation and lack the capacity to evaluate social and physiological danger signals (Gilbert et al., 2006; Schore, 1994, 2001). This lack of evaluation restricts the modulation of how intensely emotion is experienced and is particularly the case for primitive affects such as shame that left unregulated leave the threat regulation system in a state of intensive overwhelm (Schore, 2002). At this point, a person may enter into a new cycle and start to EE.

4.3.4 EE in the context of addiction

"like for some people, it's smoking or gambling or drinking" – Nicole

"I don't need to do it all the time, but the drive is there when I need to do it" – Todd

Addiction, habit or drive?

All participants compared, and some equated their EE to addictions. This finding replicates previous qualitative studies where beliefs regarding food, EE and addiction have surfaced (e.g. Curtis & Davis, 2014; Hermandez-Hons & Wooley, 2011).

The controversy surrounding the concept of food addiction is ongoing in the literature (see, for example, Burmeister et al., 2013; Cottone et al., 2019; Rogers & Smit, 2000, 2000). Some theorists argue that frequent EE becomes analogous to food addiction over time, mediating psychological distress and increased BMI (Bourdier et al., 2018). Studies demonstrating decreased HPA axis activity from associated opioid release during eating are referenced in support of addiction models (Adam & Epel, 2007). However, others argue that neuroadaptive effects, such as withdrawal symptoms characteristic of pathological addiction, are absent (Rogers & Smit, 2000).

Regardless of the wider debate on EE's validity as 'truly pathological' addictive (Rogers & Smit, 2000), addiction is an important and powerful construction within participants meaning-making. All participants made comparisons of their EE to other behaviours generally considered as potentially addictive, e.g. drinking alcohol (David, Iris, Tish, Todd and Nicole), smoking (David, Iris, Tish, Nicole and Ellaine), taking drugs (David and Iris), exercise (David), sex (Todd) and gambling (Nicole).

The concept of addiction appeared to be used by participants to emphasise the functionality of their EE and connotate a more powerful and relentless construct than habit. Iris commented that sometimes she feels scorned by healthcare professions and intimations that living with obesity has been "self-inflicted". At such times Iris states wanting to express that deep reasons underpin her EE. Evers et al. (2009) surmise that there is a potency attributed to EE, and this is conveyed by Tish's emphasis on EE being different to "comfort eating" and "not about will-power". The potency perhaps feels best captured by conceptualising it as or alongside an addiction.

Comparing or equating EE with addiction seems to help assimilate the phenomenon for the individual. The label 'addiction' can then serve as a tool when explaining EE to others that implies a need for support and understanding (see Elaine's example in chapter 3.6.3). This example supports Ziauddeen & Fletcher's (2018) suggestion that an addiction label provides a (potentially stigma reducing) explanatory narrative for EE

in the context of obesity. However, and perhaps particularly important to this study's population group, addiction also implies a construct where recovery is possible.

Todd described his EE as "a very strong drive" that is "there when I need to do it". Still emphasising EE's function, 'drive' perhaps provides a useful alternative conceptualisation to addiction that returns to escape theory (Heatherton & Baumeister, 1991; Kaplan & Kaplan, 1957). Escape theory is applied to describe behaviours that involve a motivated effort to escape self-awareness. Todd implies that the drive and motivation are only there if he needs them to be, implying a sense that control is located with Todd. The concept of EE as a drive aligns with the compassion-focused 'threat, drive and soothe' model of affect regulation (Gilbert, 2013).

A (mal)adaptive coping strategy

The participants presented EE as a coping mechanism that allows them to self-soothe, regulate intense emotion and escape threat that feels overwhelming to the self. This reasoning, in itself, is compelling. However, participants also framed EE as a positive alternative to other 'escape behaviours' (Heatherton and Baumeister, 1991), increasing its power further. For David, EE is conceptualised as an alternative to the alcoholism he was determined to avoid. Todd, conversely, sometimes now drinks when he cannot continue eating; however, he stated that before his surgery, EE brought better release than alcohol.

Tish has used food as a coping mechanism all her life, but like Ellaine, her EE increased after giving up smoking. Both women identified that they now eat when they would have previously smoked. Tish described EE as "probably an incredibly healthy thing to do". Overall the participants implied that they consider EE an adaptive rather than maladaptive coping strategy (Zeidner & Saklofske, 1996), although also recognise it as entangled with their weight gain and obesity.

4.4 Quality and Research Rigour

I have structured my evaluation of the study around the guiding points for quality in qualitative research set out by Yardley (2000). Referring to these principles throughout

the research process has allowed me to attend to the quality and ethical standards necessary to produce credible research.

Sensitivity to context

The research began from the premise that there is a need to attain a 'bottom up' understanding (Cooper, 2001; Haraway, 1988) of the lived reality of EE as told from the perspective of people who attend an NHS obesity and weight management service Maintaining sensitivity to context has, therefore, been inherently important. Working at an obesity service provided me with some initial understanding of the clinical context; this was furthered through an extensive review of the literature, which yielded existing research across a breadth of clinical and theoretical fields. The research was scrutinised according to NHS ethics procedures; participant well-being has remained a priority. I have had an ethical responsibility to ensure that the subsequent analysis and discussion remained rooted in the situated knowledge of the participants who kindly gave up time to contribute to research they consider needed. Remaining reflexive throughout the research encouraged me to consider our participant research-practitioner relationship (Hoffman, 2007).

Commitment and rigour

I have remained committed to the research question enabling participant experience to be contextualised through referencing a comprehensive and up-to-date review of relevant theory and research. The in-depth, open-ended interviews allowed participants to richly describe their experiences as autonomous experts by experience. The literature revealed EE to be complex and multifaceted; IPA proved apposite for exploring many of its parts while allowing a coherent presentation of the phenomenon as a whole. Analysis followed a systematic stepwise procedure that was informed by methods previously outlined by experts in the field (Langdridge, 2007; Smith et al., 2009).

Transparency and Coherence

The analysis began with my thorough immersion in the data, and each stage has been rigorously documented. For increased transparency, exemplars of the process are provided in the appendices (from appendix P onwards). Participants were given written information outlining the research and knew how their anonymised data would be

used. Strategies to increase validity in IPA include peer critique and thorough reflection (Davidsen, 2013); I participated in organised seminars held with my cohort of doctoral candidates where peers provided feedback on the study. Later in the chapter, I include a reflexive statement outlining where I position myself within the research. My supervisor and I regularly met to discuss the process as the analysis evolved; these meetings have allowed the research to benefit from a second and knowledgeable perspective. Supervisory feedback and discussion have ensured that participant experience has consistently remained central to my interpretations, subsequent thematic findings and discussion, allowing the research to describe what it purports (Mason, 2018).

Impact and Importance

The importance of understanding more about obesity and the medico-psycho-social factors influencing eating behaviour, including EE, has been repeatedly asserted within the field for many years (e.g. Arnow et al., 1995; Bruch, 1964; Kaplan & Kaplan, 1957; Robbins & Fray, 1980). It is crucially important that more is learnt about how to best support people to reduce EE that they consider perpetuating their obesity and related increase risk of ill-health. Early studies suggest that EE has increased since the WHO declared the novel coronavirus pandemic in March 2020 (McAtamney et al., 2021, 2021; Robinson et al., 2021), and particularly so among people who have an existing high BMI (Cecchetto et al., 2021). The risk of death from covid-19 increases by 90% in people who have a BMI of over 40 (PHE, 2020a, 2020b). All participants in the study had a BMI considerably above 40. It is hoped impact will stem from the voices of the participants and that in disseminating their lived experience, further research that informs sensitive stigma-free practice and increases awareness follow. My suggestions for future research are provided in section 4.8.

4.5 Limitations

There are key limitations to the study that are important to note in considering its findings and planning for future work.

Of particular concern is a lack of diversity in the sample demographic; all participants were of White British ethnicity. There are many important perspectives unheard. This significant limitation can be explained partly by a low referral rate of people racially minoritised to the obesity psychology team and service where recruitment took place. However, it is also reflective of the worrying lack of intersectionality in UK medical and health research (Crenshaw, 1990; Kapilashrami & Hankivsky, 2018; Redwood & Gill, 2013; Smart & Harrison, 2017) and is particularly relevant to the current research area, given the prevailing racial inequalities both to developing obesity and of poorer outcome from health conditions associated with obesity as fore-fronted currently in COVID-19 outcomes (Bhala et al., 2020).

Another important perspective missing from the sample includes those who (as highlighted by the BPS, (2019)) live with severe obesity and likely also experience EE but cannot access NHS services due to being housebound. The absence of people from these groups highlights the disadvantages of recruiting from a single service; further work across and beyond weight management services is warranted.

Sampling for IPA is usually purposive and small-scale; this allows detailed exploration of a phenomenon from the viewpoint of people in a specified context (Smith et al., 2009). To the extent that all participants in the study experienced EE, live with obesity, attend an NHS tier 3 weight management service and reside in the Eastern region of England, sampling was purposively homogenous. However, considerable heterogeneity also existed within the sample; participants came from a range of socio-economic and educational backgrounds; two have undergone bariatric surgery; others were attending the obesity service for the first time. All participants had an experience of previous therapy, although therapeutic models varied. The age range of participants was wide. Time constraints limited triangulation; repeating the study with different methods and analytic frameworks could increase validity.

It is known that sometimes people diagnosed with BED emotionally eat (Haedt-Matt & Keel, 2011b; Pinaquy et al., 2003), but eating in response to affect is not listed as part of the ICD diagnostic criteria for BED. This study's research focus has been the phenomenon of EE, and participants categorically talked about eating because of emotional distress. However, several characteristics are listed as associated with BED in the DSM-V, e.g., eating quickly, eating without hunger and feeling guilty afterwards.

It might be that some of the examples provided in the research are experiences of EE in the context of obesity *with (or with traits of)* binge eating disorder. This possibility does not distract from negative affect being the precursor to eating and highlights the importance of considering the underlying distress within EE in either context regardless of diagnostic label; however, it should be considered in reading the findings. Overlap between more 'automatic' instances of EE and BED is discussed in section 4.3.1.

4.6 Epistemological Reflexivity

Heidegger argued that phenomenological description inevitably brings interpretation; in turn, interpretation inevitably brings with it the researcher (Davidsen, 2013; Heidegger, 1962). Heidegger (1962) considered interpretation to be how understanding develops "the working-out of possibilities projected in understanding" (p. 189). I found the analysis process wide-ranging and realised that many possibilities of meaning could lie within one phenomenon.

Langdridge (2007) emphasises that phenomenology intends to narrate genuine first-person lived experience and that to achieve this ongoing reflection is essential both of the researcher's role (discussed in section 4.7) and how the research proceeds. Smith and Eatough (2007) describe a phenomenological researcher, having a dualistic role; being like the participant through shared "mental faculties" but differing in that they are "always engaging in second-order sense-making of someone else's experience" (p. 36). As such, IPA involves a double hermeneutic, which involves rich engagement and interpretation on the part of both the "researcher and researched" (Peat et al., 2019, p. 7). In this research, the double hermeneutic arose through my seeking to 'make sense' of participants 'making sense' of their world and particularly their experiences of EE.

Entering the 'hermeneutic circle'; moving between the data, my preconceptions, the participants meaning-making and my own; or as Husserl referred the 'parts' and the 'whole' of phenomenological experience has been a process of trust (Davidsen et al., 2013; Smith & Eatough, 2007). I have needed to trust IPA's iterative nature, learn to trust my interpretations of participant interpretations and recognise my subjectivity

rather than fearing it may cloud the research. Importantly I have needed to acknowledge the trust participants have put in me to hear, interpret and share their stories. I found my analysis and discussion became more fluid as this trust grew. The thorough analysis approach that IPA requires helped me develop this confidence through a systematic, rigorous procedure that I feel retained the idiographic within the findings (Denscombe, 2010; Langdridge, 2007; Smith et al., 2009).

IPA has proved complementary to my stance as a counselling psychologist; both promote the holistic, emphasise the humanistic and aspire to allow an individual to examine their experiential reality in a supportive and congruent environment. This natural fit between methodology and my professional outlook helped rapport building and has kept the research authentic.

4.7 Personal Reflexivity Statement

Kagan (2007) emphasised that people and their relationships are inextricably linked within the situational context that they meet. I believe that professionally we have an ethical responsibility to be committed to reflexive and reflective practice; however, there is always something of our 'humanness' that we will inevitably (and I would argue rightly) bring to our work as researchers and clinicians. Occasionally throughout this thesis, I have included reflections on my reactions to particular aspects of the research context or data. For transparency, I outline below where I consider myself situated within the research overall.

My interest in the psychological aspects of living with obesity has arisen from a two-year training placement at an obesity service. Before beginning the placement, my understanding and awareness of obesity were limited; and I was naive to many of the psychological, physiological and practical difficulties of daily life people living with obesity encounter. I quickly learned that for many people losing weight is much more than 'eating healthier' and 'exercising more'. Weight loss from the starting point of being severely obese is a long and, for many people challenging psychological process which occurs parallel to a myriad of bodily, relational, dietary and other changes. Not all people living with obesity have experienced poor mental health,

relational difficulties or ACEs; however, even without these additional challenges, it is a demanding process, and there are often setbacks. As a counselling psychologist, I believe that these struggles exemplify why a holistic person-centred approach to providing support is essential.

I have learned that people come to the service from diverse socio-economic backgrounds; deprivation is often a problem with people sometimes explaining that they would be in a better financial position continuing their current diet. Sometimes, genetic and or endocrine conditions make weight loss hard, or people have to take essential obesogenic medications. I have seen first-hand that it takes courage and determination for people to walk into therapy groups ridden with self-consciousness and shame and that this applies across genders.

Whilst I am aware that approximately half of adults attending specialist weight management and obesity services have experienced childhood adversity, I have been struck by how many people attend with unresolved trauma. The findings have highlighted enmeshment between participants trauma and EE experiences; this leaves me perturbed that there are not currently NICE guidelines guiding good practice for trauma care within weight management services. I fully support the BPS call for change (BPS, 2019). As the research has unfolded, I have become increasingly aligned to the position of van Strien et al. (2020) that whilst calorie-controlled diets can bring fast weight loss, often the psychological components of obesity remain unattended.

At the time of the interviews, I believe that I had more 'insider' knowledge regarding EE and living with obesity than at the start of the placement. However, I cannot profess to know exactly how it feels to be living with obesity or feeling trapped in a cycle of emotional eating. My BMI has always fallen within or just under the healthy range, and I tend towards 'under-eating' in response to low mood. For those participants who met with me in person or via video, it will have been apparent that I do not live with obesity; this may have impacted what felt comfortable to discuss if they considered us to lack shared understanding. The participants and I came to the interviews with dual roles; they as 'patient' and 'interviewee', myself as 'researcher/interviewer' and 'trainee psychologist'. While I emphasised that we were meeting in a research rather than clinical context, all participants were aware of my being a colleague to the other staff

they meet with at the service. This dynamic may also have positioned me as an 'outsider' and impacted the relationship between us.

There are some commonalities between myself and the participants. Although I do not have experience of being overweight or regular EE, aspects of the experiences described had personal resonance for me. I know how it can be to have experienced low self-esteem, recurrent severe depression and to carry shame. I also have my own experience of difference, resulting from vision impairment and a neurological condition; I know first-hand how damaging the stigmatisation that continues to surround mental and physical ill health and disability can be. These are not aspects of myself that participants will have been aware of, but they are or have been a part of my life-world and likely shape my clinical and research practice.

4.8 Implications for further research

4.8.1 Changes to methodology

Repeating the study to include a larger sample size and wider demographic is indicated. A practical way of doing so may be to run focus groups to collect data across a range of weight management settings (see Ogden et al., 2020, for a recent example of using focus groups to explore lived experience of obesity). Extending to a mixed-methods study could further findings and add generalisability to the research not possible with the current design. Intersectional work is needed, and all future work in this area needs to include minoritised people at the highest risk of obesity.

4.8.2 Awareness.

Further investigation is required to understand the apparent changes in content consciousness that can occur during EE. Clarity regarding whether dissociation is a potential mediator for EE (and perhaps vice versa) for a subgroup of people is particularly pressing. Such further research has the potential to contribute to the evidence base for using intervention strategies that are known to help reduce dissociation, including EMDR (Shapiro, 1989, 2017) and DBT (Linehan, 2014) for reducing EE. Extending the research presented by Palmisano et al. (2018) might be a

good starting point and include evaluating the occurrence of psychological and somatoform dissociation in people living with obesity who regularly emotionally eat with and without co-existing BED.

4.8.3 Memory Systems

Further research into EE and memory may provide interesting insight given the apparent value participants placed on sensory experience when consciously engaged in EE and the strength of participants' belief that eating will improve their affect. In particular, further work concerning the role of anticipatory effects in EE and exploring the accessibility, recalling and encoding of positive sensory and negative content memories throughout the process is indicated.

4.8.4 EMDR

There is growing evidence that EMDR can help reprocess addiction memories (Hase et al., 2008) and current findings suggest exploration of the use of EMDR to help reduce emotional eating in the context of living with severe obesity is warranted. Whilst EE or, indeed, food addiction is not considered a 'pathological' addiction; the findings suggest that participants identify it as an *addiction-like* behaviour. EMDR is increasingly used as a mainstream intervention for helping people with PTSD (NICE, 2018) and combined with other therapies, shows promise for reducing the impact of complex trauma (Hart et al., 2010). Furthermore, EMDR is showing promise as a helpful intervention for eating disorders (Balbo et al., 2017), including for BED (Sojcher et al., 2012) and a systematic literature review of a small number of random control trials indicate potential benefit for affective disorders, psychosis, substance use disorders, and chronic back pain (Gómez et al., 2017).

4.8.5 Target Emotions

Further research might concentrate on the role of anger within EE and particularly for people who present with trauma histories. Such research may inform the development of interventions specifically for eating in response to anger (as discussed by Strodl & Wylie, 2020).

4.8.6 Attachment

Whilst EE in the context of obesity is not currently considered an eating disorder, the high prevalence of likely insecure attachment styles among the current participants suggests that building on Mantilla et al. (2019) may be useful. Further research could look at an individual's relationships to their EE and offer insight into the potential roles of attachment-related mechanisms and the suitability of attachment focussed interventions, including family therapy.

4.8.7 Mindfulness

A better understanding of how mindfulness might best encourage non-reactive awareness in people who regularly EE is needed. Such research should explore how best to introduce and teach the practice to incorporate its use into daily life in patients attending weight management settings, given that existing research often used nonclinical populations (Lattimore, 2019; Levoy et al., 2017; Pidgeon et al., 2013). Research needs to clarify if, how and when mindfulness may best be used safely and sensitively for the estimated fifty per cent of adults who attend obesity services that have a history of childhood adversity, including complex trauma (BPS, 2019; Treleaven, 2018).

4.8.8 Smoking cessation

Further work is warranted to establish if the finding that EE is considered a 'healthier alternative' to other habits and addictions is a generalisable conceptualisation. If so, there is a potential implication for preventative work, particularly during smoking cessation.

4.9 Clinical Implications

Existing theory relating to EE extends across psychological perspectives. The findings of this research have shown the lived experience of EE in the context of living with

severe obesity to be similarly multi-layered and necessitating integrative psychological intervention that can accommodate this breadth.

In this penultimate section, I will propose the findings suggest that adopting a trauma-sensitive and pluralistic approach may provide a beneficial way forward for helping people understand and reduce EE. However, whilst advocating pluralistic psychotherapy, this research ultimately endorses current assertions that NICE guidelines for obesity care must enhance and inform evidence-based intervention that forefronts trauma-informed, holistic, psychological support (BPS, 2019). Furthermore, guidelines should incorporate best practice for supporting people to reduce EE as a matter of urgency.

4.9.1 Pluralistic Practice

Buckroyd and Rother (2008) point out that for people living with obesity who find emotions impact their eating, methodological flexibility is needed. The current study identifies EE to involve a range of experiential processes that are likely to need a tailored, flexible range of interventions. For example, instances, when an individual is very engaged and hyper-focussed on eating may require different strategies to occasions when eating is more automated and dissociative or resembling dissociation. It may be that when awareness of eating is hyper-focused, reducing the attention paid to the sensory properties of eating and instead concentrating on normalising intense emotion and acknowledging that it is safe to do so in the present moment is helpful. However, when awareness of the in-the-moment experience of eating decreases, grounding techniques that help individuals remain in the present by engaging the senses and disengaging from dissociation might be more appropriate (Sanderson, 2013). In both cases, learning ways to foster feelings of safety, calmness, and perspective will be important (Boon, 2011; Evans & Coccoma, 2014).

Proponents of pluralistic counselling and psychotherapy position the approach as synchronistic to counselling psychology's holistic stance, highlighting shared axiology through the value placed on individuality, appreciation of diversity, and personal autonomy (Cooper & McLeod, 2010; McAteer, 2010). Moreover, the epistemological position of pluralism appreciates that there are multiple ways of knowing and that understanding complex phenomena such as EE will involve client understandings,

therapist interpretations and subsequent reconstruction by both (Cooper & Dryden, 2015; Cooper & McLeod, 2012). This acknowledgement of multiplicity fits with how EE has been shown in this research to be a phenomenon that requires a careful understanding of an often diverse process. The pluralistic approach acknowledges that experience and knowledge are dynamic and may require a different stance at different times (McLeod, 2013).

Through collaborative formulation and goal setting, pluralistic therapy might offer an uncomplicated but extensive frame for supporting people to reduce EE through its intrinsic flexibility and facilitate client autonomy. The therapeutic process includes collaboratively setting a 'goal,' e.g., reducing EE frequency. The practitioner would identify and discuss with the client 'tasks' ahead to move towards the goal, e.g., taking time together to understand the context in which the individual's cycle of EE has developed, pre-empt times when someone may be more prone to emotionally eat and attempt some advanced 'problem-solving including planned alternative coping strategies in advance. The most appropriate 'methods' for the individuals' presentation could then be drawn on and, together with the therapeutic relationship, serve as a vehicle for change (Cooper & McLeod, 2010).

I consider person-centred work that confers empathy, unconditional positive regard and congruence towards the client (Rogers, 1961) fundamental to counselling psychology. A pluralistic approach allows therapies to co-exist and build on this humanistic foundation by introducing therapeutic methods that, although theoretically different, may suit the needs of the unique individual (Mahrer, 2007). Person-centred groundwork can be integrated as appropriate to the formulation with evidence-based therapeutic approaches that current theory suggests may help particular aspects of someone's EE.

Therapy might include CBT with a compassion-focused stance, encouraging individuals to learn alternative techniques, including mindfulness to soothe or sit with distressing emotion, regulate responses to perceived threats and reduce EE (Gilbert, 2010; Goss, 2011; Shuman, 2012). There is also a growing evidence base suggesting that interventions that target experiential avoidance can help reduce EE, e.g. ACT (Forman & Butryn, 2016; Hayes et al., 1996; Hill et al., 2015) and DBT (Boutelle et al., 2018; Braden et al., 2020; Linehan, 1993) or an integration of the two (Hayes et al.,

2011). Utilising approaches to help individuals who struggle with their sense of self, particularly when emotionally eating, may also be fitting, e.g., schema therapy, transactional and narrative therapies. In allowing evidence-based approaches to be blended using a structured framework, the “something more” that Tish described she feels needed to help reduce EE may be found.

4.9.2 Trauma-Sensitive Practice

The findings emphasise that the infrastructure of obesity care, including approaches for reducing EE, must be trauma-sensitive. Increased psycho-education for service users and the wider multi-disciplinary team can help facilitate such practice (Berger & Quiros, 2016; Dietz et al., 2015; Evans & Coccoma, 2014; Reeves, 2015). I suggest current findings fully support calls to ensure psychologists trained in a range of trauma-informed interventions are attached to weight management services (BPS, 2019).

Additionally, training is needed among wider MDTs to ensure that all practice is trauma-sensitive, including thorough social history taking (Felitti, 2002; Palmisano et al., 2016, 2018b) and referral to the psychology team if a person discloses a history of unresolved trauma. Illustrating training material with case examples may increase awareness of EE, its underlying causes and reduce stigma towards obesity across healthcare professionals in general.

4.10 Summary and Conclusion

This research has presented lived experience of emotional eating (EE) from the perspective of people who attend a tier 3 NHS obesity and weight management service. Participants described EE as inexorably linked to living with obesity and holds a depth of meaning that demarcates from the perhaps more surface and colloquial label of ‘comfort eating’. The phenomenon and the emotions behind them have been considered a ‘tangle’ that requires personal and professional understanding to unwind.

Conscious awareness during EE has been conceptualised along a spectrum with instances of hyper-focus and fully engaged eating and times when eating becomes

automated, and awareness of the in-the-moment experience of eating decreases. The study has particularly emphasised the ongoing and cumulative impact of shame on EE. Figure 4.1 below summarises the experiential process of EE as presented by participants and discussed in this chapter.

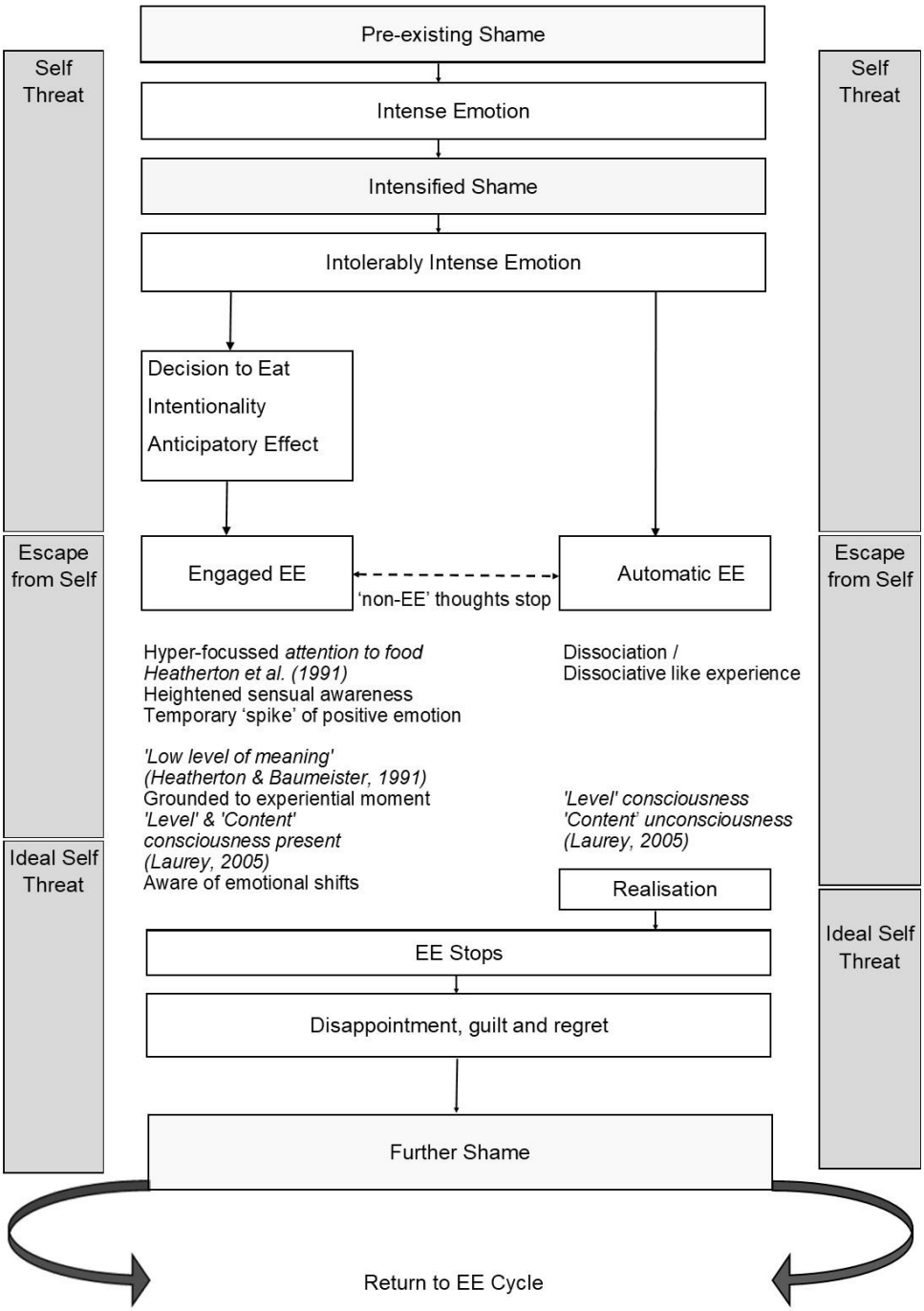

Figure 4.1 Lived experiential process of emotional eating

Emotion shifts throughout the process, with EE, attributed to having the capacity to bring welcome relief, even if short-lived, from emotions that at that moment can feel intense, overwhelming and unbearable. For many, EE has grown from deep-rooted psychological distress, sometimes dating back to childhood. It has become a familiar part of life that can be difficult to dislodge from a perpetuating cycle driven by low self-esteem and shame. Similar to the process itself, the conceptualisations participants hold about EE based on their lived experience are potent and support prioritising therapeutic work with the emotional dimensions of EE and any unresolved trauma prior to behavioural. Conceptualisations are represented in figure 4.2 and are positioned with existing key theory and salient cognitions.

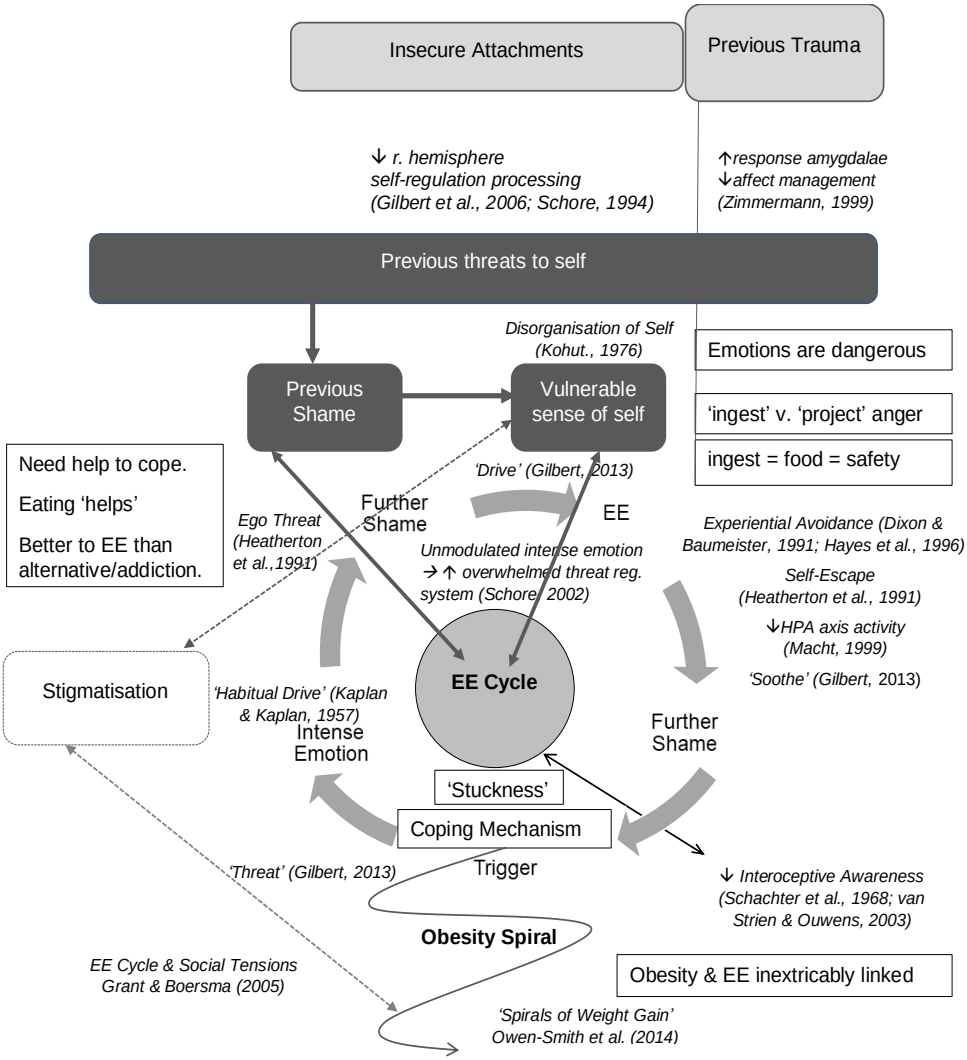

Figure 4.2 Key patient conceptualisations of emotional eating

Conclusion

Overall, the phenomenon has been presented with a purported power to transpose feelings, stop thoughts and refocus bodily awareness. Although disappointment and regret follow EE, sometimes this feels preferable to the index emotion, particularly where EE has become a coping or avoidant mechanism in the context of unresolved trauma. In some cases, people are unable to conceive of other ways to regulate affect, reiterating Tish's remark:

"I actually don't know whether there is something more powerful to me than food".

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Appendices

Appendix A: An overview of current NHS provision in the UK for weight and obesity management

Obesity Care

The current pathway for obesity care started in 2014 and comprises a tiered system; beginning with 'universal prevention services' such as public health campaigns. At tier two time-limited, community-based 'lifestyle' weight loss programs are offered. Tier three services are considered specialist and are delivered by a clinician-led multidisciplinary team. At tier four bariatric surgery is offered to candidates assessed as suitable. NICE specify that a referral to tier four cannot be made until a person has worked with a tier three team first (NICE, 2020; Public Health England, 2017).

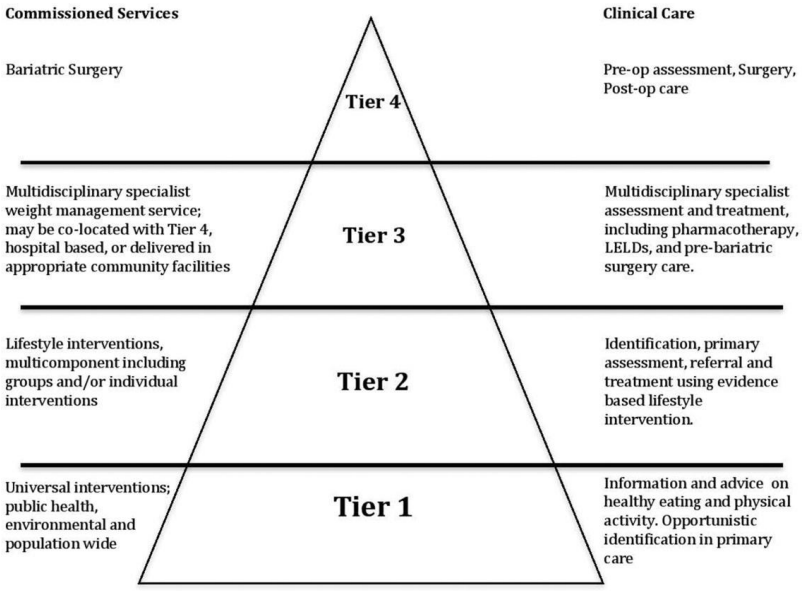

Figure A1. Tiered Model of Weight Management Services (Jennings et al., 2014)

Weight Management Services and Bariatric Surgery in the UK

Patients are referred to tier three specialist weight management service if they are considered to have 'complex severe obesity' with a BMI ≥ 40 or a BMI ≥ 35 with comorbidities including diabetes (Hughes, 2015). Tier three recommendations can include closely monitored low-calorie control diets, behavioural interventions and pharmacological treatments. There is an increasing call for weight management services to increase focus on emotionally driven and addictive-like eating behaviour (Bourdier et al., 2018).

If surgery is decided to be a safe and indicated option at tier four, the most frequently opted for procedure is fitting a 'laparoscopic adjustable gastric band' (LAGB)

(Broadbent et al., 1993). The precise mechanism for weight loss with the gastric band is not fully understood; however, it is known that the passage of food is slowed down, activating peripheral satiety mechanisms making a person feel full sooner (Burton & Brown, 2011).

If the LAGB is unsuitable, a Roux-en-Y gastric bypass is often suggested (Wittgrove & Clark, 1994) which involves stapling the stomach to create a smaller pouch; this restricts how much food can physically be eaten, increases feelings of satiety and suppresses appetite (Higa et al., 2011; Ratcliffe et al., 2014; Wittgrove & Clark, 2000). Surgery can be life changing for some people; although the procedures can bring significant side-effects, require ongoing diet modification and sometimes psychological difficulties such as depression and poor body image persist (Jumbe et al., 2017; Kinzl et al., 2011; Sarwer & Heinberg, 2020). For others surgery is unsuccessful, and emotional eating is a known mediator for less weight loss than expected (Canetti et al., 2009; Dalrymple et al., 2018; Unal et al., 2019; Walfish, 2004). There are frequent appeals for greater provision of psychological follow-up post-surgery (BPS, 2011, 2019; Ristanto & Caltabiano, 2019; Sheets et al., 2015).

The importance of therapy in supporting people to lose weight is long recognised (see for example Smith, 1948). However, psychological resources and types of interventions available within weight management services varies greatly across trusts. Dependent on commissioning, some areas can only offer psychological assessment whereas elsewhere, more comprehensive interventions are provided (BPS, 2019; Ratcliffe et al., 2014). NICE state the necessity of psychological input but there is a lack of operational definitions and clear policy stipulating the exact remit of psychology within weight management services (NICE, 2020; Ratcliffe et al., 2014).

Where offered, the provision of weight management services are reported as valuable by service users (Hughes, 2015). However, there are people for whom interventions have not helped and others who lose a significant amount of weight but subsequently regain it (Canetti et al., 2009; Elfhag & Rössner, 2005; Unal et al., 2019). Emotional eating is often cited as a reason for weight regain and more understanding is needed to help services devise appropriate support interventions tailored towards reducing this risk (Abramson, 1993; van Strien, 2018).

Psychological Support for Emotional Eating

Ideally, weight management services should offer integrated psychological care matched to an individual's specific need (Annesi et al., 2016; BPS, 2019; Cassin et al., 2018a). However, neither obesity nor emotional eating are formally conceptualised as psychological conditions, and therefore no evidence-based guidelines exist on best practice for managing emotional eating (Brownwell & Walsh, 2017; Larkin et al., 2017; Marcus & Wildes, 2009). Annesi et al. (2016) described emotional eating interventions to mostly be 'atheoretical' p. 289. Work is needed to develop a theoretical framework for fully integrative psychological care, including intervention for emotional eating (Cassin et al., 2018b; Sogg et al., 2018).

Research focusing on emotional eating intervention is growing (Annesi & Johnson, 2020; Juarascio et al., 2020). Strategies to support emotional regulation taken from Dialectical Behavioural Therapy (DBT) (Braden et al., 2020; Braden & O'Brien, 2020) and Acceptance and Commitment Therapy (ACT) (Forman & Butryn, 2016; Hill et al., 2015; Litwin et al., 2017) are showing promise, but longitudinal work is lacking. Halvgaard (2015) documented a single case study where emotional eating in a fifty-five-year-old woman decreased following eye movement desensitisation and reprocessing (EMDR). Overall much more work is needed to develop interventions for emotional eating; however, integration of mindfulness and Compassion Focused Therapy (CFT) with traditional CBT for emotional eating has started to be utilised with some success (Carter et al., 2018; Goss, 2011; Mantzios & Wilson, 2015).

Mindfulness

Mindfulness is increasingly used as a strategy to help people manage their emotional eating (Mantzios & Wilson, 2015; Sogg et al., 2018; Yu et al., 2020). Mindfulness and mindful eating exercises serve to redirect focus from current emotional stresses and weight loss goals towards the experience of eating, thereby increasing awareness of internal cues rather than external signals to eat (Schnepper et al., 2019; Sogg et al., 2018; Warren et al., 2017). The practice intends to encourage non-judgemental awareness and seeks to accept and observe rather than change internal events (Egan & Fox, 2017; Sogg et al., 2018). Beccia et al. (2020) explored women's experiences of a mindful eating program for binge and emotional eating; findings suggested that mindfulness-based interventions may reduce emotional eating behaviours by empowering women to make positive food choices without emphasis on weight. Through focusing on the present moment, mindfulness is purported to reduce eating triggered in response to automatic thoughts and emotions that occur during rumination and worrying about the future (Sogg et al., 2018). Katterman et al. (2014) conducted a systematic review of the use of mindfulness as a primary intervention for emotional eating, binge eating, and weight change; interventions were shown to reduce emotional eating behaviour across samples but did not predict measures of weight change. Whilst research has shown mindfulness programs to be associated with reducing emotional eating, these have often taken place in non-clinical settings. Further study is needed to establish the therapeutic advantage of mindfulness in a bariatric clinical setting including longitudinal work (Lattimore, 2019; Levoy et al., 2017; Pidgeon et al., 2013).

Compassion Focussed Therapy (CFT)

Therapeutically, CFT seeks to train the mind to encourage internal experiences of warmth, safety and capacity to self soothe (Gilbert, 2013, 2014). Self-compassion is theorised as an 'evolutionary cognitive competence' that confers humans capacity to form symbolic 'self-representations' which allow socially advantageous close relationships to be formed (Gilbert & Woodyatt, 2017). However, in turn, the affect regulation system is primed to sense threats to a person's internal and external world (Gilbert, 2009). This hypersensitivity to threat is particularly developed in people with high levels of self-criticism, shame and 'self-directed hostility'; attributes often expressed by people struggling with emotional eating and obesity (Carter et al., 2018; Gilbert et al., 2014; Gilbert, 2009).

CFT, in combination with ACT for group therapeutic approaches, has been shown to decrease weight self-stigma, shame, emotional eating, and BMI (Mantzios & Wilson, 2015; Palmeira et al., 2017). Furthermore, theorists argue that increased self-compassion can serve as a protective factor against weight regain (Lee, 2018; Stephens, 2014). Comparative effectiveness work is needed to establish which clinical populations are most likely to benefit from CFT (Egan & Fox, 2017; Sogg et al., 2018). There are calls for self-compassion to be further defined to provide greater construct validity in quantitative studies (Barnard & Curry, 2011).

The BPS has recommended that NICE guidelines be updated to include clear evidence-based guidance addressing psychological factors perpetuating a person's struggle with obesity, including past traumas, 'comfort eating' and emotional regulation (BPS, 2019). Further ongoing research to increase understanding of how people experience their emotional eating and any previously tried strategies is needed to help inform such guidance.

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Appendix B: Informed Consent Form

IRAS No: 259320 ICF v.4 12.08.19

Experiences of 'Emotional Eating' Research Project

CONSENT FORM

Please place your initials in the right hand box to indicate your consent.

1.	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve:	
	• being interviewed by the researcher	
	• allowing the interview to be audiotaped	
2.	I understand that any information I provide is **confidential**, and that no information that could lead to my identification will be disclosed in any reports or articles on the project, or to any other party. No identifiable personal data will be published. The only exception to preserving your confidentiality being if you were to disclose information that raises concern either for your own safety or that of someone else's e.g. if you told me you were planning to hurt yourself or someone else. If this were to occur; I would talk to other professionals as appropriate.	
3.	I understand that my participation is **voluntary**, that I can choose not to participate in part or all of the project, and that I can withdraw my consent at any stage of the project without being penalised or disadvantaged in any way. I understand this research is completely separate to my ongoing care provided by the clinical team at the obesity service.	

4.	I agree to the arrangements detailed in the participant information sheer for data storage and archiving.	
5.	I agree to the use of anonymised quotes in any reports or publications.	
6.	I agree to the researcher contacting my GP to inform them of my intention to take part in the study.	
7.	I agree to take part in the above study.	

This information will be held by City, University of London as data controller and processed for the following purpose(s): analysis of student research project.

I give consent to my involvement in this research project:

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix C: Participant Information Sheet (amended March 2020)

IRAS No: 259320 PIS v.6 4.3.20

Experiences of 'Emotional Eating' Research Project

PARTICIPANT INFORMATION SHEET

Before deciding if you would like to take part in this research it is important that you understand why the research is being carried out and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish.

If there is anything that is not clear or if you would like further information, please contact me either by email vicki.norton@anonymised.nhs.uk or telephone XXXXX XXXXXX Ext: XXXXX.

What is the purpose of the study?
I would like to learn about experiences of emotional eating and what these experiences mean to people currently seeking help from an obesity service. The research is being fully supervised by psychologists at City, University of London and will form part of my post-graduate degree in counselling psychology. I hope to gain a better understanding of people's experiences of emotional eating that may also be of interest to other psychologists and healthcare professionals planning interventions in this area.

Why have I been invited?
During your recent assessment at the anonymised service based at anonymisedchunkoftext, you kindly agreed to being contacted about research projects currently being carried out that are related to the service.
I am keen to talk to people who:

- are aged over 18;
- have experience of regular 'emotional eating';
- are currently under the care of a specialist NHS Weight Management Service;
- would feel comfortable talking to me about their experiences of emotional eating.

Do I have to take part?
No.
Participation in the research is **completely voluntary** and you are at liberty to **change your mind and withdraw from the study.** You are not obliged to answer any questions. If you

choose not to take part, this will not influence your treatment at anonymisedchunkoftext anonymisedchunkoftextin anyway.
It is up to you to decide whether or not to take part. If you do take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time whilst the study is running without giving a reason. However, once data has been anonymised participants will no longer be able to withdraw data.

What will happen if I take part?

- Taking part in the study involves speaking with me for a one-off interview that will last for approximately one hour.
- Prior to the interview you will be given opportunity to ask further questions and I will email you a consent form which I will ask you to sign/initial and return to me.
- The interview will be conducted by phone or by video call (whichever you prefer) and recorded using a digital voice recorder.
- Interviews will take place between January and May 2020 at a date and time of your convenience.

What do I have to do?

- The interview is estimated to last for around an hour.
- You will be able to ask for breaks during this time and you are not obliged to answer any questions you do not feel comfortable answering.
- I will have a list of questions that I may refer to during the interview but you will be encouraged to speak about your experiences in depth.

What are the possible disadvantages and risks of taking part?

The nature of the topic being researched is by its nature emotive. Should you be negatively affected by what we are discussing you can ask to stop the interview. Details of a clinician at the obesity service as well as suggestions of further sources of support will be made available to you. With your permission your GP will be informed that you are taking part.

What are the possible benefits of taking part?

It should be emphasised that the research interview will be different from a psychological therapy session, it will however allow you the opportunity to reflect on your experiences of emotional eating in depth.

What will happen when the interview finishes?

- One the interview has finished and recording has been stopped we will discuss how you are feeling having taken part.
- You will have the opportunity to ask me any further questions or raise concerns.
- You will be given a debriefing sheet summarising the research aims and providing details of sources of support if needed.
- I will ask if you would like me to send you a summary of the research findings when the study is complete.
- After we have finished our meeting, I will transfer the audio recording to a secure computer and will password encrypt the file. The audio will then be deleted from the recording device.

- I will listen to the audio recording and type it up word for word. However, at this point I will remove any information that could identify you and any names (including your own) will be replaced with alternatives.
- Any notes I have taken during the interview will also be anonymised.
- A process of analysis will later be followed that will allow me to draw out important themes you have shared in the interview.
- This same process will be followed with the transcripts of other people who have taken part.
- All themes identified from individuals will then be looked at collectively and any common themes across participants identified.
- Common themes will be presented as findings and the implications of these findings discussed in further reports on the research. All participant personal information will continue to be kept anonymous.

Will my taking part in the study be kept confidential?
Yes.

- With the exception of myself no-one will have access to data that could be identified as yours.
- Examiners of my final research will not have access to your personal data.
- Once my degree is completed audio recordings will be destroyed.
- Any further work that uses the information collected in the study will continue to keep the personal information of participants anonymous.

The only exception to the above would exist should you disclose information to me that caused me to have concerns regarding your safety or the safety of others e.g. if you were to discuss an intention to physically harm yourself or someone else in any way. In such an instance we would stop the interview and I would discuss these concerns further with you and seek urgent input from relevant health/social care services and/or other professionals involved in your care.

What should I do if I want to take part?
Your input in the study would be highly valued.

- If you would like to be contacted further about taking part or have any questions then please contact me either by email on vicki.norton@anonymised.nhs.uk or telephone XXXX XXXXXX.
- I will then make contact with you to arrange a convenient time for a short discussion by phone to discuss the research further and if you are happy to be interviewed make arrangements convenient to you.

What will happen to results of the research study?
The results of the study will be used anonymously in the write up for my doctoral thesis. Should any other report or publication draw on these results your anonymity will always be preserved. You will be asked if you would like to receive a document outlining the overall research findings.

What will happen if I do not want to carry on with the study?
Whilst the study is still running (i.e., at the interview and transcription stage) you are free to withdraw your consent and stop your involvement with the study without explanation and doing so will not impact your treatment at the anonymisedchunkoftext service in any way.

Who has reviewed my plans for the study?
This study received initial approval by the academic team at City, University of London.
It was subsequently reviewed by the South East Scotland Research Ethics Committee (REC) 2 - 4 Waterloo Place, Edinburgh, EH1 3EG to ensure that it meets the ethical requirements of projects being conducted throughout the NHS.
The Research and Development team at anonymised chunkoftextNHS Trust have also reviewed and approved the research.

Further information and contact details
For further information please do not hesitate to contact me using my email

Prinicipal Investigator/Clinical Contact at anonymised chunk of text clinic:

Dr Anonymised Name

Anonymised Text, Anonymised Text

Anonymised Text

Anonymised Text Anomised

Anonymised, Anonymisedchunkoftext NHS Foundation Trust

Anonymised Text, Anonymised, Anonymised, Anonymised, ANO NAN

Tel: XXXX XXXXXX Ext: XXXXXX Fax: XXXX XXXXX

Should you have any other concerns about my conduct as a researcher or how the research is being run; my research supervisor Dr Fran Smith can be contacted by email on fran.smith.1@city.ac.uk.

If you would prefer to speak to someone impartial who does not have any regular direct contact with myself, please contact the Patient Advice and Liaison Service (PALS) XXXXX XXXXXX anonymisedchunkoftext.nhs.uk

Thank you for taking the time to read this information sheet.

Vicki Norton

March 2020 - Version 6.

Please note that this study is separate from your clinical care and you are under no obligation to take part

Appendix D: Invitation to participate letter

[redacted]
NHS Foundation Trust
[redacted]
vicki.norton@[redacted]

[Insert Date]

Dear Volunteer,

Re. Invitation to take part in research on experiences of 'Emotional Eating'

I am writing to you because during your recent clinic assessment you kindly agreed to be contacted regarding research being carried out at the Obesity Service.

I am a trainee counselling psychologist currently working at the service and completing my doctoral degree at City, University of London. As part of my training, I am carrying out a researchproject focusing on the experiences of people using the service who report regular 'emotional eating'.

An information leaflet explaining more about the research and what taking part would involve is included with this letter. If you would like to be contacted further about taking part the study please do get in touch by emailing vicki.norton@anonymised.nhs.uk or by returning the opt-in form giving your consent to be contacted using the stamped addressed envelope provided.

Many thanks for taking the time to read this letter.

Yours sincerely,

[redacted]

Vicki Norton
DPsych Research Candidate & Trainee Counselling Psychologist

Please note that this study is separate from your clinical care and you are under no obligation to take part.

Appendix E: Letter to GPs

[redacted]

vicki.norton@[redacted]

[Insert Date]

Dear Dr [Insert Name],

Re: [Insert] [Insert} – 'Emotional Eating' Research Participation
[Insert]

I am writing to inform you that your patient [Insert Name] has consented to take part in a qualitative research project that is exploring patient experiences of 'emotional eating'.

Participation will involve being interviewed by myself in a one-off interview likely to take approximately one hour. Please find attached further information on the study and a copy of the consent form that your patient has signed agreeing to take part in the research.

If you would like to discuss this matter further or have any concerns, please don't hesitate to contact me.

Yours sincerely,

[redacted]

Victoria Norton
DPsych Research Candidate & Trainee Counselling Psychologist.

Appendix F: REC provisional opinion letter and request for further information

South East Scotland REC 02
2 - 4 Waterloo Place
Edinburgh
EH1 3EG

Telephone: 0131 465 5674
Fax:

03 June 2019

Dr Fran Smith
Department of Psychology
City, University of London
Whiskin Street, London
EC1R 0JD

Dear Dr Smith

Study Title:	**The Lived Experience of Emotional Eating: An Interpretive Phenomenological Analysis among patients attending a Tier 3 Obesity Service.**
REC reference:	**19/SS/0078**
Protocol number:	**N/A**
IRAS project ID:	**259320**

The Research Ethics Committee reviewed the above application at the meeting held on 29 May 2019. Thank you for attending to discuss the application.

Provisional opinion

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.
Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

1. Please reconsider/ revise process to contact/follow up participants after their initial approach – Consider incorporating SAE and amend all related documentation appropriately e.g. invitation letter, protocol.
2. Once participant documentation finalised please run past a few participant representatives for their views on comprehensibility and include any amendments suggested where appropriate.
3. Please confirm the examiner will not have access to raw data/personal data.
4. Contradictory BMI levels given sometime states 30 elsewhere 35 . Please confirm which is correct.
5. Similarly contradictory times given for interview says will last one to two hours in protocol but then in PIS it is stated as 60 to 90 minutes. If it is up to two hours the participants need to know that (PIS).

6. Please provide information on debrief process and upload debrief sheet.
7. Please confirm revised end date to the study.
8. An appropriate lone working policy should to be used and followed. Please confirm
9. Please confirm provide reassurance over student ability to be confident to deal with outcome of second application of suicide questionnaire.
10. Need to see final PIS ICF and proposals/protocol uploaded on IRAS with appropriate version and dates on them.
11. Please provide clarification over extent to which data may be shared with others. Why are the medical notes being referred to. This sentence was not complete in the IRAS form. Please explain.

Participant information sheet specifics

a. In the Do I have to take part section of the PIS the first word should be No.
b. Typographical and grammatical checks are needed. Specific examples as follows

- Withdraw from the study , not withdraw from the stud
- 'be negatively be affected' - too many 'be's
- 'include being part of research they might bring future benefit' the 'they' should be 'that'
- limits to confidentiality if you were to disclose - this sentence needs 'would be', or 'exist' in it
-

c. The wrong REC is detailed as having reviewed the study please amend appropriately.
d. Reference that may find it a beneficial experience thought to be coercive please remove /reword appropriately
e. Need contact details of an independent adviser
f. Needs to be clear about debrief process
g. Needs to be clear over the length of the interview
h. Simplify terminology used for example avoid words such as transcribed and pseudonymous and try another form of words more understandable to a lay person e.g. transcribed (written up word for word) pseudonymous (information that can identify you will be removed)
i. A NHS email used at the top of the PIS but then a university one in the text. The NHS email is probably more appropriate to be given to patient participants. Please reconsider and be consistent over which email provided.

<u>Consent form</u>

a. Please review wording of bullet point 2 and be clearer what is intended. Please amend appropriately.
b. Add clause to allow for GP to be informed.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact the REC Manager.

When submitting a response to the Committee, the requested information should be electronically submitted from IRAS. Please refer to the guidance in IRAS for instructions on how to submit a response to provisional opinion electronically.

Please submit revised documentation where appropriate underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. You do not have to make any changes to the REC application form unless you have been specifically requested to do so by the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 03 July 2019.

Extract of the meeting minutes

Ethical issues raised by the Committee in private discussion, together with responses given by the researcher when invited into the meeting

The Chair telephoned and welcomed the student Mrs Vicki Norton to the meeting

- **Social or scientific value; scientific design and conduct of the study**
  The Committee highlighted that it had been stated in the application that their intent was to involve current service users in the development of the interview schedule. The Committee queried if this had actually happened.

  The researcher advised that unfortunately they had not been able to do this as had not had sufficient time.

  The Committee recommended that some participant group representatives should finally be given any revised participant documentation for final comment regards comprehensibility e.g. PISCF and interview schedule.

  The student accepted this.

  Recruitment arrangements and access to health information, and fair participant selection
  The Committee noted that it appeared that the initial approach was to be by the direct care team and steps taken to ensure data protected.

  The student confirmed this was what was planned.

  The Committee asked for clarification of the planned process to follow up participants after their initial approach. How was she going to follow up after the written information pack was sent in the post.

  The student explained what was intended.

It appeared to the Committee that the intention was currently that the participant was to email the researcher. If so the Committee agreed it would be helpful to make sure this was made clear in the invitation letter or whatever the process was to be. Indeed the Committee was unclear if emailing the researcher was the only way or the best way for potential participants to say they wanted to take part and asked the researcher to reconsider.

The Committee agreed that it would be useful if a self addressed envelope / reply opt in could be provided for return to the researchers. So potential participants could indicate their willingness to be contacted before the researcher got in touch.

The student agreed to rethink and provide an appropriate method to contact/follow up participants after their initial approach.

The Committee highlighted that in the application at A27-3 there appeared to be some typos and insertion of partial sentences that appear to have come from somewhere else e.g. 'check that there is no reason that they should not be taking part in the study.

The student confirmed this was an error.

The Committee asked was there to be an upper age limit for the study and if so was it to be set at 75.
The student confirmed that she had not set an exact absolute upper age limit for the study but it was expected to be around 75.

There were variations in the sample size given throughout the documentation at one point it was stated to be 10 and then elsewhere 6. The Committee asked for confirmation of the sample size
The student confirmed the intended sample size to be 10.

Similarly contradictory BMI levels were given of 30 and then elsewhere 35.

The Committee asked for clarification of the length of interview. Would it last one to two hours as stated in the protocol or as stated in the PIS 60 to 90 minutes. If it was up to two hours the participants would need to know that. The Committee was unclear if perhaps the longer time included the debrief.

The student accepted that the PISCF should be clearer over timings and agreed to amend participant documentation appropriately.

The Committee highlighted that there seemed to be no debrief sheet included in the application for them to review. One of the protocol appendices also referred to a debriefing phone call after the session. If this was planned then the Committee agreed that it would need to be made clear to participants in the PIS.

The researcher agreed to confirm and revise where appropriate.

The Committee highlighted that the start and end dates of the study would need to be revised.
The student accepted this.

The Committee highlighted that there was a pilot mentioned in the protocol and requested clarification of whether this has this been done and is so what, if any, changes would be made.

The researcher agreed to confirm and revise where appropriate.
The Committee was reassured by all of these responses.

- **Favourable risk benefit ratio; anticipated benefit/risks for research participants (present and future)**
  The Committee highlighted that as individuals might be seen outside the obesity service - the students safety was a priority. The Committee asked how this would be risk assessed and how would the student ensure her own safety. .An appropriate lone working policy would need to be used and followed.
  The student was little unclear over this and did not know of the specific policy to be followed.
  The Committee recommended that an appropriate lone worker policy should be established and would need confirmation that it would followed.

  The researcher agreed to comply with this recommendation.

- **Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

  The Committee considered that overall in the application the emotive / potentially distressing nature of the topic for research participants had been acknowledged, and that the researchers would provide appropriate further support to participants if this was needed.

  However the Committee in particular did ask for reassurance over the student's confidence and ability to deal with the outcome of the second application of the suicide questionnaire.

  The student provided reassurance over this and advised she was experienced and had training and would be supported to do this. If necessary she would stop the interview and signpost the individual to support services and refer up appropriately.

  The Committee further discussed their recommendation that the researchers look to incorporate a self addressed envelope/ return slip to indicate wish to be contacted regarding the study i.e. opt in procedure. So that potential participants were not cold called. As currently state will phone if there was no response to a first approach.

The student accepted this and agreed to revise the process and look to include SAE.

The Committee was reassured by these responses.

The Committee asked for clarification over extent to which data may be shared with others. The Committee asked why were the medical notes being referred to. This sentence was not complete in the IRAS form.

The researcher provided some clarification.

- **Informed consent process and the adequacy and completeness of participant information**

The Committee confirmed the researcher would need to upload the final versions of the PIS ICF and protocol all with appropriate updated control version numbers and dates on them.

In addition as discussed earlier the participant documentation once finalised should be run past a few participant representatives for their views on comprehensibility and any amendments suggested should be incorporated where appropriate.

A full final typographical and grammatical check of documentation would also be needed.

The Committee agreed that details for an independent adviser should be provided.

Participant information specifics some examples of typos and inaccuracies were highlighted that would needed amended were highlighted by the Committee and would be laid out in full in the opinion letter. .

For example the Do I have to take part section of the PIS the first word should be No.

The student accepted this and agreed to do this.

In relation to the consent form the Committee were unclear at bullet point 2 what the intention was and what was being consented to. This would need to be made clearer. In addition a clause would be needed to allow for GPs to be informed.

The Committee highlighted again that the Information letter, PIS, consent form and interview schedule provided as appendices in Research Proposal document differed from those uploaded as independent documents.

Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		03 May 2019
GP/consultant information sheets or letters [GP Letter V1.0]	1	03 May 2019
Interview schedules or topic guides for participants [Interview Schedule V1.0]	1	03 May 2019
IRAS Application Form [IRAS_Form_08052019]		08 May 2019
IRAS Application Form XML file [IRAS_Form_08052019]		08 May 2019
IRAS Checklist XML [Checklist_08052019]		08 May 2019
Letter from sponsor [Sponsor Letter April 2019]		03 May 2019
Letters of invitation to participant [PP Invite V1.0]	1	03 May 2019
Participant consent form [PP Consent Form V1.0]	1	03 May 2019
Participant information sheet (PIS) [PP Info v. 1.0]	1	03 May 2019
Referee's report or other scientific critique report [V1.0]		03 May 2019
Research protocol or project proposal [Research Proposal v.1.0]	1	03 May 2019
Summary CV for Chief Investigator (CI) [V.1.0]		03 May 2019
Summary CV for student [C.V v.1]		03 May 2019
Summary CV for supervisor (student research) [CI CV 1.0]		03 May 2019

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

19/SS/0078	**Please quote this number on all correspondence**

Yours sincerely

[redacted]

Mr Lindsay Murray
Chair

Email: [redacted]@nhslothian.scot.nhs.uk

Enclosures: *List of names and professions of members who were present at the*

meeting and those who submitted written comments.

Copy to: *Prof Emmanuel Pothose*

South East Scotland REC 02

Attendance at Committee meeting on 29 May 2019

Committee Members:

Name	*Profession*	*Present*	*Notes*
[redacted]	General Practitioner	Yes	
	Senior Research Nurse	No	
	Retired	Yes	
	Study Coordinator	Yes	
	Priest	Yes	
	Research Midwife	Yes	
	Senior Lecturer	Yes	
	Business Development Manager	Yes	
	Health & Safety Manager	Yes	
	Clinical Psychologist	Yes	
	Lawyer	No	
	Professor Emeritus	Yes	
	Senior Research Nurse	Yes	
	Emeritus Professor of Speech Pathology	No	
	Clinical Research Manager	No	

Also in attendance:

Name	*Position (or reason for attending)*
[redacted]	REC Manager
Mrs Victoria Norton	Student

Appendix G: Letter responding to REC detailing changes and clarification

Victoria Norton
c/o Dr Fran Smith
Department of Psychology
City, University of London
Whiskin Street, London
EC1R 0JD

Mr [redacted]
Chair
South East Scotland REC 02
2 - 4 Waterloo Place
Edinburgh
EH1 3EG

02/07/19

Dear [redacted],

Re: REC reference 19/SS/0078 IRAS Project ID: 259320

Thank you for your letter dates 03/06/19 requesting further information and clarification regarding my research project.

I have uploaded to IRAS revised documents for the PIS, ICF, protocol and suggested interview schedule – changes are highlighted in yellow. Please find in italics below the points the committee asked me to clarify followed by my response.

1. Please reconsider/revise process to contact/follow up participants after their initial approach – Consider incorporating SAE and amend all related documentation appropriately e.g. invitation letter, protocol.

Including a SAE and associated 'opt-in' reply slip has now been included in the protocol and the invitation letter amended accordingly.

2. Once participant documentation finalised please run past a few participant *representatives for their views on comprehensibility and include any amendments suggested where appropriate.*

Volunteer participant representatives have looked at the documentation and reported that they found it clear. They commented that the PIS is lengthy but found bullet points helped to break the information down.

3. Please confirm the examiner will not have access to raw data/personal data.

The examiner will not have access to any raw or personal data. Documentation now contains a statement to this effect.

4. Contradictory BMI levels given sometime states 30 elsewhere 35. Please confirm which is correct.

People included in the study will have a BMI of 35 or above. This is now stated consistently throughout the documentation.

5. Similarly contradictory times given for interview says will last one to two hours in protocol but then in PIS it is stated as 60 to 90 minutes. If it is up to two hours the participants need to know that (PIS).

The interviews are expected to last for approximately one hour. This is now stated consistently throughout the documentation.

6. Please provide information on debrief process and upload debrief sheet.

The debrief process is now summarised on page 13 of the protocol. A copy of the briefing document to be used is appended to the uploaded protocol on page 49 (Appendix F).

7. Please confirm revised end date to the study.

The data collection stage of the study is expected to end in December 2019. The finalised thesis is due to be submitted on 30th September 2020.

8. An appropriate lone working policy should to be used and followed. Please confirm

The obesity services policy on lone working will be followed.

9. Please confirm/provide reassurance over student ability to be confident to deal with outcome of second application of suicide questionnaire.

Participants will be asked to complete the PHQ-9 questionnaire a second time. Any participant who now has scores suggesting that they are in crisis and/or are expressing suicidal ideation and/or are now engaging in deliberate self-harm will not be included.

The student researcher is appropriately trained to administer this questionnaire and to discuss such risks and safety plans with participants.

In such an instance or if similar cause for concern occurs during the interview, the student will stop the research and refer the participant urgently for crisis intervention, her clinical supervisor and participants clinicians will also be informed. The student will remain with the participant until help is accessible.

10. Need to see final PIS ICF and proposals/protocol uploaded on IRAS with appropriate version and dates on them.

The PIS ICF and proposal/protocol has been updated and uploaded to IRAS, saved as version 2 and dated 02/07/19.

11. Please provide clarification over extent to which data may be shared with others. Why are the medical notes being referred to. This sentence was not complete in the IRAS form. Please explain.

It is not considered necessary for medical notes to be referred to for the purposes of this study. The patient information document outlines what will happen to participant data and provides assurance re. maintaining confidentiality.

a. In the Do I have to take part section of the PIS the first word should be No.

The word ‘no’ has now been inserted as the first word of this section.

b. Typographical and grammatical checks are needed. Specific examples as follows

- Withdraw from the study, not withdraw from the stud

- 'be negatively be affected' - too many 'be's

- 'include being part of research they might bring future benefit' the 'they' should be 'that'

- limits to confidentiality if you were to disclose - this sentence needs 'would be', or 'exist' in it

These typographical and grammatical errors have now been corrected.

c. The wrong REC is detailed as having reviewed the study please amend appropriately.

The correct REC is now documented.

d. Reference that may find it a beneficial experience thought to be coercive please remove /reword appropriately

The PIS section beginning 'what are the possible benefits of taking part?', has been rewritten and now states "It should be emphasised that the research interview will be different from a psychological therapy session, it will however allow you the opportunity to reflect on your experiences of emotional eating in depth".

e. Need contact details of an independent adviser

The contact details of the hospitals local R and D department are now provided.

f. Needs to be clear about debrief process

The debrief process is now outlined on p.13 of the protocol and is mentioned in the PIS.

g. Needs to be clear over the length of the interview

All documentation has now been amended to state that interviews will last for approximately one hour.

h. *Simplify terminology used for example avoid words such as transcribed and pseudonymous and try another form of words more understandable to a lay person e.g. transcribed (written up word for word) pseudonymous (information that can identify you will be removed)*

Terminology has been simplified as suggested.

i. A NHS email used at the top of the PIS but then a university one in the text. The NHS email is probably more appropriate to be given to patient participants. Please reconsider and be consistent over which email provided.

My NHS email address is now provided in the PIS in place of the university one.

Consent form

a. Please review wording of bullet point 2 and be clearer what is intended. Please amend appropriately.

Point two of the consent form has been reworded and shortened.

It now reads “I understand that any information I provide is confidential, and that no information that could lead to my identification will be disclosed in any reports or articles on the project, or to any other party. No identifiable personal data will be published.”

b. Add clause to allow for GP to be informed.

Point 6 of the consent form now includes the clause “I agree to the researcher contacting my GP to inform them of my intention to take part in the study”.

Please don’t hesitate to contact me if any further clarification or modifications are needed.

Many thanks for your time in considering my study.

Yours Sincerely,

Victoria Norton
DPsych Candidate & Trainee Counselling Psychologist
City, University of London

Appendix H: REC favourable opinion letter

Lothian NHS Board

South East Scotland Research Ethics Committee 02

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000

www.nhslothian.scot.nhs.uk

Date 26 July 2019
Your Ref
Our Ref

Enquiries to : [redacted]
Extension: 35674
Direct Line: 0131 465 5674
Email: [redacted]@nhslothian.scot.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

26 July 2019

Dr Fran Smith
Department of Psychology
City, University of London
Whiskin Street, London
EC1R 0JD

Dear Dr Smith CI
Cc Student Mrs Victoria Norton

Study title:	**The Lived Experience of Emotional Eating: An Interpretive Phenomenological Analysisamong patients attending a Tier 3 Obesity Service.**
REC reference:	**19/SS/0078**
Protocol number:	**N/A**
IRAS project ID:	**259320**

Thank you for your letter of 2 July 2019 and emails of 19th July 2019 , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion
The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

It is a condition of the REC favourable opinion that all clinical trials are registered on a publicly accessible database. For this purpose, clinical trials are defined as the first four project categories in IRAS project filter question 2. For clinical trials of investigational medicinal products (CTIMPs), other than adult phase I trials, registration is a legal requirement.

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites listed in the application subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper [Cover letter to REC]	1.0	02 July 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		03 May 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [PI Schedule]		03 May 2019
GP/consultant information sheets or letters [GP Letter V1.0]	1	19 July 2019
Interview schedules or topic guides for participants [Interview Schedule]	2	19 July 2019
IRAS Application Form [IRAS_Form_08052019]		08 May 2019
Letter from sponsor [Sponsor Letter April 2019]		03 May 2019
Letters of invitation to participant [PP Invite]	2	19 July 2019
Participant consent form [PP Consent Form]	3	19 July 2019
Participant information sheet (PIS) [PIS]	3	19 July 2019
Referee's report or other scientific critique report [V1.0]		03 May 2019
Referee's report or other scientific critique report [RP Feedback]		03 May 2019
Research protocol or project proposal [Research Protocol]	2	19 July 2019
Summary CV for Chief Investigator (CI) [CI CV]		03 May 2019
Summary CV for supervisor (student research) [CI CV v.1.0]		03 May 2019

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/SS/0078	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]

Mr Lindsay Murray
Chair

Email: [redacted]@nhslothian.scot.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Prof Emmanuel Pothose

Appendix I: HRA response table

IRAS no: 259320 Response v.1 12.08.19

HRA and HCRW Assessment Response Table

HRA and HCRW assessment - Further Information Required	Response from the applicant
Supervisor CV: IRAS A74 states that the student has a clinical and a research supervisor, but only one supervisor CV submitted. Please clarify and provide the missing CV if appropriate via IRAS	Dr anonymisedtext is now uploaded to IRAS – saved in the checklist under 'other documents/clinical supervisor CV'
Changes to the Participant Information Sheet(s) (PIS) and Consent Form(s): • To add agreement for access to medical notes by the NHS Trust in the consent form (in accordance with the data protection act) http://www.hra-decisiontools.org.uk/consent/examples.html • To add IRAS number to PIS and consent form (in line with HRA standards) • To refer to the standard HRA GDPR transparency wording and update the GDPR wording in the PIS with limited rights to access, change or move information, length of time personal data stored for, what personal data the NHS Trust will collect and if this is shared with the sponsor. Ensure that information in the first paragraph and text from Option A are included, in accordance with GDPR. https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/transparency-wording-public-sector/ The correct link for the DPO contact should be amended to: https://www.city.ac.uk/about/governance/legaldata-protection	Participant medical notes do not need to be accessed by the NHS Trust for this research project. IRAS no: 259320 has been added to the PIS and consent form (highlighted on form in yellow, uploaded on 12/08/19 and saved as version 4 for both documents). Standard HRA GDPR transparency wording information has now been included from the first paragraph and option A (selection 1). The link has been amended to https://www.city.ac.uk/about/governance/legal/data-protection.

Appendix J: HRA approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Fran Smith
Department of Psychology
City, University of London
Whiskin Street, London
EC1R 0JD

Email: [redacted]

20 September 2019

Dear Dr Smith

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The Lived Experience of Emotional Eating: An Interpretive Phenomenological Analysis among patients attending a Tier 3 Obesity Service.**
IRAS project ID:	**259320**
Protocol number:	**N/A**
REC reference:	**19/SS/0078**
Sponsor	**City, University of London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **259320**. Please quote this on all correspondence.

Yours sincerely,

[redacted]

Approvals Specialist

Email: [redacted]

Copy to: *Prof Emmanuel Pothose*
vicki.norton@city.ac.uk

Appendix K: Research and Development Team Approval

NIHR |

[redacted]

15/10/2019

R&D ref: A095391

[redacted]

Dear Dr [redacted]

IRAS ID: 259320

The Lived Experience of Emotional Eating: An Interpretive Phenomenological Analysis among patients attending a Tier 3 Obesity Service.

REC Ref: [redacted]

Thank you for sending details of the above named study.

The R&D department has received the HRA Approval letter and reviewed the study documents. The project has been allocated the internal R&D reference number of **A095391.** Please quote this in all future correspondence regarding this study.

Capacity and capability to conduct this study at [redacted] Trust is confirmed. Recruitment can commence at this site from the date of this letter.

We would like to take this opportunity to remind you of your responsibilities under the terms of the UK Policy Framework for Health and Social Care Research, applicable to Researchers, Chief Investigators, Principal Investigators and Research Sponsors. We would also like to remind you of the requirement to notify R&D of any amendments or changes made to this study.

You will be aware that the Trust is subject to national reporting requirements for first patient recruitment within 70 days. Further details on this can be found on the NIHR website:
htt o: // www.nihr.ac.u k/ research-and-imoact/nhs-research-oerf orm ance/ oerformance-in-initi ating-and-deliverinq-research/
If you have any questions or concerns about this, please contact me.

I wish you every success with this study.

Yours sincerely

[redacted]

Research Governance Lead

[redacted]

Appendix L: Notification of Non-Substantial/Minor Amendments(s) for NHS Studies

Partner Organisations:
Health Research Authority, England
NIHR Clinical Research Network, England
NHS Research Scotland
NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland

Notification of Non-Substantial/Minor Amendments(s) for NHS Studies

This template must only be used to notify NHS/HSC R&D office(s) of amendments, which are NOT categorised as Substantial Amendments.

If you need to notify a Substantial Amendment to your study then you MUST use the appropriate Substantial Amendment form in IRAS.

Instructions for using this template

For guidance on amendments refer to http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/

This template should be completed by the CI and optionally authorised by Sponsor, if required by sponsor guidelines.

This form should be submitted according to the instructions provided for NHS/HSC R&D at http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/which-review-bodies-need-to-approve-or-be-notified-of-which-types-of-amendments/ . If you do not submit your notification in accordance with these instructions then processing of your submission may be significantly delayed.

Study Information

Full title of study:	The Lived Experience of Emotional Eating: An Interpretive Phenomenological Analysis among patients attending a Tier 3 Obesity Service.
IRAS Project ID:	259320
Sponsor Amendment Notification number:	

Sponsor Amendment Notification date:	
Details of Chief Investigator:	
Name [first name and surname]	Dr Fran Snith
Address:	City, University of London Whiskin Street, London
Postcode:	EC1R 0JD
Contact telephone number:	
Email address:	Fran.Smith.1@city.ac.uk
Details of Lead Sponsor:	

Name:	City, University of London Trudi Edginton Head of Department of Psychology
Contact email address:	Trudi.Edginton@city.ac.uk
Details of Lead Nation:	
Name of lead nation *delete as appropriate*	England
If England led is the study going through CSP? *delete as appropriate*	No
Name of lead R&D office:	Research & Development Department Anonymised Anonymised NHS Foundation Trust

Partner Organisations:
Health Research Authority, England NIHR Clinical Research Network, England
NHS Research Scotland NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland

Summary of amendment(s)

This template must only be used to notify NHS/HSC R&D office(s) of amendments, which are NOT categorised as Substantial Amendments.

If you need to notify a Substantial Amendment to your study then you MUST use the appropriate Substantial Amendment form in IRAS.

No.	Brief description of amendment *(please enter each separate amendment in a new row)*	Amendment applies to *(delete/ list as appropriate)*		List relevant supporting document(s), including version numbers *(please ensure all referenced supporting documents are submitted with this form)*		R&D category of amendment *(category A, B, C) For office use only*
		Nation	Sites	Document	Version	
1	Change to the mode of data collection: requesting to conduct interviews via use of telephone or Skype rather than face to face. This is to ensure participant and researcher safety in light of the current COVID-19 outbreak and is in line with HRA guidelines and City, University of London requirements.	England	All sites or list affected sites			
2						
3						
4						
5						

[Add further rows as required]

Notification of non-substantial / minor amendments; version 1.0; November 2014 Page 244 of 276

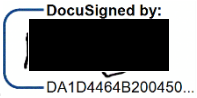
Partner Organisations:
Health Research Authority, England NIHR Clinical Research Network, England
NHS Research Scotland NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland

Declaration(s)

Declaration by Chief Investigator

I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.

I consider that it would be reasonable for the proposed amendment(s) to be implemented.

Signature of Chief Investigator: …… 

Print name: …Fran Smith…..……

Date: …26th March 2020……..

Optional Declaration by the Sponsor's Representative (as per Sponsor Guidelines)

The sponsor of an approved study is responsible for all amendments made during its conduct.

The person authorising the declaration should be authorised to do so. There is no requirement for a particular level of seniority; the sponsor's rules on delegated authority should be adhered to.

I confirm the sponsor's support for the amendment(s) in this notification.

Signature of sponsor's representative: ……..……

Print name:……..……

Post: ……..……

Organisation:……..……

Date:……..

Appendix M: The Emotional Eating Scale

Emotional Eating Scale

Developed by Arnow, Kenardy and Agras, 1994.

We all respond to different emotions in different ways. Some types of feelings lead people to experience an urge to eat. Use the form below to identify the extent to which the following feelings lead you to feel an urge to eat, by ticking the appropriate box.

Feelings	No desire to eat (score 0)	A small desire to eat (score 1)	A moderate desire to eat (score 2)	A strong urge to eat (score 3)	An overwhelming urge to eat (score 4)	D	A X	A
Resentful								
Discouraged								
Shaky								
Worn out								
Inadequate								
Excited								
Rebellious								
Down								
Jittery								
Sad								
Uneasy								
Irritated								
Jealous								
Worried								
Frustrated								
Lonely								
Furious								
On edge								
Confused								
Nervous								
Angry								
Guilty								
Bored								
Helpless								
Upset								

Scoring the scale

Each column is assigned a number, from 0 on the left (no desire to eat) through to 4 (an overwhelming desire to eat) on the right. Score your results accordingly, and add up the total. The highest possible score is 100.

What do the scores mean?

This rating scale is not a diagnostic tool. It rather seeks to give the person completing it a better indication whether they have a potentially unhealthy relationship with food.

Score	Meaning
0-25	You probably have a very healthy relationship with your food
25-46	Your reliance on food to help manage your emotions is probably impacting on your quality of life
47-100	It is quite likely that you have a very significant reliance on using food to help you manage emotions, and this may risk your long terr health

What kinds of feelings give me an urge to overeat?

The emotional eating scale also groups the feelings into three main categories: Depression (D), Anxiety (AX) and Anger/Frustrated (A). By looking at your score for each of these three categories of emotions you can see whether a particular type of feeling tends to result in an urge to eat whereas another type of feeling is less likely to. For example, someone may find that depression type and angry type feelings produce a strong urge to eat, but anxious type feelings tend not to.

Using the columns on the right hand side total up your score for each category of feelings:

Depression _____. The maximum score is 20, so a score above 10 suggests these types of feelings tend to lead to a moderate or stronger urge to eat.

Anxiety_____. The maximum score is 36, so a score above 18 suggests these types of feelings tend to lead to a moderate or stronger urge to eat.

Anger/Frustration_____. The maximum score is 44, so a score above 22 suggests these types of feelings tend to lead to a moderate or stronger urge to eat.

Appendix N: Interview Schedule/Agenda

Draft Intv. Schedule v.2 19.07.19

Draft Interview Schedule and Prompts

- Introduce Myself
- Rapport Building
- Remind Participant they do not need to answer a question if they don't feel comfortable doing so
- Remind PP they may withdraw consent and stop the interview at any point.

Introductory Questions:

- People tend to use the term 'emotionally eating' in different ways; what does it mean for you?
- Generally speaking what is your relationship with food?

Thoughts, Feelings and Embodied Experience of Emotionally Eating:

- Is it possible to describe a recent example of a time when you ate in response to how you were feeling?
- Are you able to explain the sorts of thoughts and feelings you were experiencing?
    - just beforehand – what were you thinking? what were you feeling?
    - whilst 'emotionally eating' – what sort of thoughts were you having? how did you feel?
    - what were your thoughts and feelings immediately afterwards?
- Do you notice anything in your body when emotionally eating? (i.e. sensation of hunger/emptiness/anxiety signs?)
    - before?
    - during?
    - after?
- Do you sometimes eat in response to any other emotions? If so, please can you tell me about a recent example? [repeat above prompts].

Beliefs and Understanding of Emotional Eating:

- Have your experiences of eating in response to your emotions influenced your beliefs about yourself?
- Do these experiences influence your beliefs about obesity in general?
- Drawing on your own experiences, what advice might you give to someone else who is struggling with emotional eating?
    - What would being kind to themselves look like?
- How would you explain emotional over-eating to someone else?

- What does ‘emotional eating’ mean to you personally?

Impact on Life:

- How does Emotional Eating affect different aspects of your life?
    - family relationships?
    - work relationships?
    - social life?
- How do you think losing weight might impact on you eating in response to emotions?
- How do your experiences of emotional eating affect your experience of weight loss?

Interview Conclusion:

- Recap what has been covered in the interview and ask participant to let me know if it sounds like I have misinterpreted their meaning.
- Are there an overall message you’d like to share regarding your beliefs and experiences of emotionally over-eating?
- Is there anything that I haven’t asked which you feel is relevant about emotional eating?

Thank participant for taking part.

Appendix O: Debrief Sheet

[redacted]

vicki.norton@[redacted]

Experiences of 'Emotional Eating' Research Project

DEBRIEF SHEET

Many thanks for speaking with me today, the issues we have discussed will be very helpful to my research which is looking at people's experiences of eating in response to their emotions.

Whilst emotional eating is something that many people often experience it is an area that is currently under researched.

This research is aiming to:

- Present experiences of 'emotional eating' among people currently attending a specialist NHS tier 3 weight management and obesity service.
- Explore how participants make sense of their experiences of emotional eating.

In doing so the research hopes to increase awareness of the psychological impact of emotional eating in relation to obesity.

I hope that you have found talking about your experiences interesting and an overall positive experience. Sometimes, talking about emotional and sensitive experiences can result in you feeling more upset than anticipated. If this is the case please do not hesitate to get in touch with any of the following people/organisations to seek support:

Your GP. When you originally gave consent to taking part in this study you also gave me permission to write to your family doctor to let them know you were taking part. They will therefore be aware that you have been discussing emotional eating with a researcher and can discuss further support options if needed.

The Psychology Team at the anonymisedanonymisedanonymisedanonymised. anonymisedanonymisedanonymisedanonymised.

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The Samaritans. The Samaritans offer a confidential listening service 24 hours a day, 7 days a week. Their free to phone number is 116 123 or visit their website https://www.samaritans.org/.

n.b. If you should find yourself feeling in crisis e.g. considering harming yourself or someone else please immediately contact your GP for an emergency appointment, take yourself to a and e or phone 111.

A self-help book that you may find helpful is 'The Compassionate Mind Approach to Beating Overeating: Series editor, Paul Gilbert (Compassion Focused Therapy)', ISBN-13: 9781845298777.

Should you have any cause for complaint or concern; my research supervisor Dr Fran Smith can be contacted by email on fran.smith.1@city.ac.uk or my clinical supervisor anonymised anonymised anonymised anonymised. Alternatively, if you would prefer to speak to someone impartial who does not have any regular direct contact with me the patient advice and liaison service can be contacted on anonymisedanonymisedanonymisedanonymised.

Again many thanks for taking part in this research. Please do contact me should you think of any further questions, feedback or concerns.

Vicki Norton

DPsych Candidate/Researcher &
Trainee Counselling Psychologist.

Department of Psychology
City, University of London
Whiskin Street
London EC1R 0JD

Appendix P: Exemplar of initial noting

An example of step 2 of analysis (initial noting in the left hand margin) taken from a section of David's interview transcript:

Exploratory Notes – (descriptive, *conceptual* **and** linguistic **use).**	**Transcript**	**Emergent Themes**
VN: Immediately prior to eating emotionally you said you might feel angry or you might feel low; do you notice anything in your body at that point?		
Initially difficult to articulate feeling. I want to hit something – tension, aggression, feeling 'violent' *wanting to release anger/emotion*	PP1: I think when I'm… (long pause), when I'm angry, I think it's, when I'm angry, it's I don't feel anything, you know as in a physical… I'm just you know, I want to hit something	
VN: Mmm		
really really low – repeated use of 'really', again indicating *significant/extremeness of low mood prior to EE.* no energy can be a part of pre-EE embodied experience *literally no energy to do anything* – 'literally' suggests it was important to PP1 to emphasise that *having no energy* when depressed is 'real' and a characteristic of being 'really, really low'.	PP1: When I'm really really low, it's often I've got literally no energy to do anything.	
VN: hmm		
PP1 *doesn't register physical feelings of hunger* before EE and repeats the earlier phrase of needing 'something to *pick me up'*. Will sometimes try coffee instead of food but on other occasions experiences a *distinct sudden desire for sugar sugar* (repeat of sugar, sugar only option?)	PP1: um, and it's stuff like that that I tend to feel, it's not physically that you actually sit there feeling hungry, it's… you are… you need something to 'pick me up', you know it's a massive cup of coffee or you know, with a huge amount	

Alongside *craving sugar,* also *craves experiencing strong taste sensation* such as sweet and sour sweets. you can go 'right' – a *decisive moment* and *plan to eat* '*pick you up*' phrase repeated again. Wants to feel energised? Mood boosted? PP1 emphasises he likes *strong flavours* whilst EE such as the bitter taste of dark choclate, very specifically now 'not sweet' but a *strong taste*. *foods experienced as 'bland' don't meet expectation* and a need to find another food prompting further search for a *stronger flavoured food and further EE.*	of caffeine in it or which is okay, but that's getting less and less effective sort of thing, or you're just right, sugar, sugar, you know, so it's like sour sweets or lots of sugar, but a strong taste of them and something that you can go 'right' and you know, just something that will pick you up that way…or its chocolate, dark chocolate, like brown chocolate, I like the bitter taste, it's not sweet, but it's a strong taste, chocolatey, and I do find also that sometimes with foods that's really bland, I now need to find another food that has that…I need flavour to it.	
VN: Yes		
In addition to having *strong taste* PP1 states the food needs *texture* to it – *further sensory dimension to experience.* PP links *boredom and EE,* foods become boring? Life becomes boring? Sense of monotony again. you *need something new to kick off – needing a change of experience* there and then, needing something 'new to kick off' life in general?	PP1: I need texture to it, and new, because you just get bored and it's…. you need something new to kick off.	

Appendix Q: Exemplar of initial noting and emergent themes

An example of step 3 of analysis taken from a section of Ellaine's transcript:

Exploratory Notes – (descriptive, *conceptual* **and** linguistic **use).**	**Transcript**	**Emergent Themes**
VN: How you think about obesity does that link to emotional eating in your mind or are they two very separate things?		
I just fill myself with a load of crap – *self deprecating, link with obesity due to food choice when EE* Points out aware that obesity can have other causes besides EE. However, for PP her *obesity considered direct consequence of EE*. yeah I just want it to stop (laughs) nervous laughter? Wants to change, 'it' – does it imply seeing EE as externalised?	PP6: Erm…I don't know really, for me being obese is linked to my emotional eating because I just fill myself with a load of crap but at the same time for other people who are obese it may be because of medical issues, you know, but for me personally it is because of my emotional eating and yeah, I just want it to stop (laughs).	**Self-deprecating over EE** **links with obesity due to food choice when EE** **obesity considered direct consequence of EE**
VN: Thank you. How would you explain emotional eating to somebody else?		
(sighs)…(long pause), it's really difficult – sighing emphasising that EE can be hard to explain to people. you are feeling a bit sort of *upset* – can it be hard to identify specific emotion? so you just go in the kitchen you *just find* whatever there is to eat and you just eat it and to *begin with that makes you feel good* – 'just find' and 'just eat' seems automatic reaction feels good at first I've done it because I wanted to feel happy so that's why I start eating – *confident that EE starts due to wanting to*	Erm…(sighs)…(long pause), it's really difficult, I mean I was trying to explain it to my friend at work the other day…that… and I sort of said to her, you know, it's like erm, you know, you (sighs), you are feeling a bit sort of upset and what have you and erm I said like to her, you know, so you just go in the kitchen and you just find whatever there is to eat and you just eat it and to begin with that makes you feel good and she was like 'yeah' she said, 'but, she said I	**EE is difficult to explain to people** **automatic reaction to upset.** **confident that EE starts due to wanting to feel happy**

feel happy. Differentiates EE from ordinarily having crisps down to wanting to change mood. Comparison to smoking helped friend to understand EE more when I'm stressed I go to the kitchen – *feeling stressed leads to EE.* you know <u>how hard</u> it is to give up smoking and that's <u>how hard</u> it is for me to not eat – directly compares smoking and EE again, both are hard to <u>'give up'</u> connotates dependence *Feelings of stress and anger towarsd other before EE.* Avoiding showing anger? Distinct temporal point of time before EE feeling <u>really</u> <u>'grumpy'</u>.	could go in the kitchen and eat a couple of packets of crisps but I'm not saying that I'm an emotional eater' and I said 'well no, you've done it because you wanted a packet of crisps, I've done it because I wanted to feel happy so that's why I start eating'. …and she eventually sort of understood, I mean she is a smoker so I said to her 'just think when your kids are stressing you out or whatever'…because she has teenagers 'I said when they stress you out you can go out to your garage and have a cigarette; I said but when I'm stressed I go to the kitchen and I said for me I said you know how hard it is to give up smoking and that's how hard it is for me to not eat…you know, those things when I'm feeling stressed, so I feel like, you know, I'm going to snatch someone's head off because I'm just feeling, you know, really grumpy at that point'.	**feeling stressed leads to EE** **directly compares smoking and EE, both are hard to 'give up'** **feelings of anger at others pre EE.** **point of time before EE feeling 'grumpy'**
VN: So you feel really grumpy at someone/something beforehand and earlier you mentioned feeling cross with yourself afterwards. Have I remembered that right?		
Anger before EE towards someone and afterwards self. internal-self afterwards.	PP6: Yeah. I get frustrated and wish I hadn't	**anger at external-other moves to anger at internal-self afterwards**

Appendix R: Exemplar of superordinate and emergent theme clusters

Superordinate themes and corresponding emergent theme clusters for Nicole (analysis step 4 identifying links between themes)

Missing social connection
Missing family prompted EE
Partner staying away for work prompted EE
Not seeing family due to lockdown
EE take-away when partner at work
Feeling 'totally' alone prompted EE
Using a helpline in that moment is helpful
Speaking to someone is essential

Thoughts and Feelings stop whilst food is frantically taken in
'you just eat' – automated
Feelings and thoughts stop
Body - during EE unaware of being full, unaware of body
Image of self 'stuffing' during EE, frantically taking food in and substituting emotions

Experiences low mood prior to emotionally eating
Feeling depressed triggers EE
Being on a 'downie' triggers EE
Being 'fed up' triggering

Sense of disappointment following EE
EE doesn't bring the feeling pp is seeking
Vicious circle with 'feeling better' never coming
Sense of having let herself down
EE is an anti-climax

Sense of overwhelm and tiredness before emotionally eating
Feelings had been 'building up' and then 'caught up' prompting EE
Can't always pinpoint the negative emotion that led to EE
Tiredness

Angry with self when eating is finished
Afterwards angry with self
Frustrated and cross with self afterwards
'A moment of weakness' – self-deprecating

Explained as a response to distress
EE is a response to something in life that hasn't gone right
Has become a reflex/automatic?
EE is familiar
EE in the hope of feeling better

Actively searching for food
Fast paced searching for available food rather than specifically choosing
Pre-EE 'active' process

Other people's words and presumed judgement triggers emotional eating
EE triggered by what other people say
EE in response to things people say
Feeling 'put down' leads to EE
Feeling discriminated against over obesity triggers feeling down which in turn leads to EE

Secrecy and Shame
Emotionally eating alone
Eating in privacy of home rather than work/public etc.,
Hoarding/hiding secret store of sweets
Shame around food eaten during EE
Double checking that a different take away is being used to prevent embarrassment and shame
Feeling embarrassed and 'ashamed' after emotionally eating

Emotional eating is distinct from 'ordinary' eating
EE distinguished from mealtime eating
EE food is kept from other foods
EE is not about hunger

Self & inner child
Hiding from partner and sisters – similar pattern when younger
Does EE momentarily remove sense of self/identity?
Shift towards self-acceptance is helping to reduce EE
altering internal dialogue

Past trauma relates to emotional eating
Sense of shame regarding traumatic life event
Events from the past relate to and are a 'big part' of the EE now
Explaining background and EE to new therapist feels a 'rigmarole'

Finding an understanding of EE
Seeking 'professional' support has been helpful in understanding EE
Tries to understand and help family to understand EE
Lacks confidence in ability to abstain from EE without therapy

Emotional eating considered a 'bad habit' and compared to addictions
EE is a bad habit that is hard to break
EE compared to smoking, gambling or drinking

Appendix S: Exemplar representation of superordinate and emergent themes with supportive keys words/quotes from the transcript

Representation of superordinate themes and corresponding emergent theme clusters for Nicole's transcript (analysis step 5)

Themes	Page number/Line number	Key words/quote
Needing social connection		
Missing family prompted EE	1/18	I hadn't seen my family for well for months really
Partner staying away for work prompted EE	1/5	when Rich wasn't here
Not seeing family due to lockdown	1/21	I saw my sister last… then we went into lockdown and that's it, and I think, just, just, it all caught up with me
EE takeaway when partner at work	6/2	I used to buy a lot of takeaways, erm, especially when he was at work
Feeling 'totally' alone prompted EE	1/17	I was totally alone
Using a helpline in 'that moment' is helpful	7/29, 7/31 8/11, 8/25	there was helplines out there
Speaking to someone is essential	7/28, 8/4	you need to speak to someone even if it's just the Samaritans, erm to just not eat

Thoughts and feelings stop whilst food is frantically taken in		
'you just eat' – automated	1/15, 1/17	you just eat
Feelings and thoughts stop	5/9	during it, I didn't feel or think anything…erm, it just was, I was just eating
During EE unaware of being full, unaware of body	2/16	you don't even register that you're full
Image of self 'stuffing' during EE, frantically taking food in, substituting emotions	5/12	I used to go home and stuff my face

Experiences low mood prior to emotionally eating		
Feeling depressed triggers EE	2/13	as when I get down or feel depressed
Being on a 'downie' triggers EE	1/15	I'd just got in a bit of a downie
Being 'fed up' triggering	2/5	I was fed up

Sense of disappointment following EE		
EE doesn't bring the feeling pp is seeking	5/24	I would eat to make myself feel better again but that feeling, it never comes
Vicious circle with 'feeling better' never coming	5/27	it's just a vicious circle going around, erm, trying to make you feel better, erm, but the feeling never comes back to feeling better
Sense of having let herself down	2/5	after I was cross with myself because I'm doing this for me
EE is an anti-climax	8/15	I didn't enjoy it, erm, not as much as I thought I would have done

Sense of overwhelm and tiredness before emotionally eating		
Feelings 'building up'	1/22	it all caught up with me
Can't always pinpoint the negative emotion that led to EE	2/13	when I don't even realise what it is
Tiredness	1/25	I'm not really sleeping much at the moment

Angry with self when eating is finished		
Afterwards angry with self	2/5	I'm angry
Frustrated and cross with self afterwards	8/17	I (pause) bollocked myself for doing it
'A moment of weakness' – self-deprecating	8/18	it was a moment of weakness

Themes	Page number/Line number	Key words/quote
Explained as a response to distress		

EE is a response to something in life that hasn't gone right	2/18, 3/13	because something in your life hasn't gone right
Has become automatic	2/17, 5/10	just eat for the sake of eating
EE is familiar	3/12	it's what I've got used to
EE in the hope of feeling better	5/12, 5/24, 5/26	hoping that it would make me feel better.

Actively searching for food		
Fast paced searching for available food rather than specifically choosing	2/15	anything sweet I can get my hands on, erm that's just there
Pre-EE 'active' process	8/26	going to eat

Other people's words and presumed judgement triggers emotional eating		
EE previously been triggered by what other people say	3/15, 5/22, 7/13	and then I'd see someone else and they'd say something else and then I would go home and I would eat
Feeling 'put down' leads to EE	3/13,	I've got used to eating when things have got to me or people have put me down
Feeling discriminated against over obesity triggers feeling down which in turn leads to EE	2/24	I don't get jobs and I feel it's because of my size

Secrecy and Shame		
Emotionally eating alone EE take-away alone	1/16, 6/2	he wasn't here and all that and he wasn't here
Eating in privacy of home rather than work/public etc.,	5/12	I used to go home and stuff my face
Hoarding/hiding secret store of sweets	6/13, 6/16	I used to order my favourite sweets which are sherbet fountains and double dips and hide them from Rich.

Feelings of shame lead to ordering takeaway from different places	6/4, 6/8-6/10	I would never order from the same take away in that week so I had about four or five different takeaways just so they didn't know I was having more than one take away a week.
Shame around food eaten during EE	4/24	no one else is going to see it apart from themselves
Feeling embarrassed and ashamed after emotionally eating	1/6, 5/15,	I didn't break it, break it, too much as soon as I had finished whatever it was that I was eating, I would feel shame

Emotional eating is distinct from 'ordinary' eating		
Emotional eating is distinguished from mealtime eating	2/14	it's not like a meal
EE food is kept from other foods	6/15	I'd buy food separate from the supermarket food…and hide them
Emotional eating is not about hunger	8/23	the thing is with the emotional eating it's not about the hunger

Self & inner child		
Hiding from partner and sisters; similar pattern when younger	6/15	it was the same when I was younger, I used to buy sweets and hide them from my sisters
Shift towards self-acceptance is helping to reduce emotional eating	3/16, 7/3, 7/13	i'm listening to me
altering internal dialogue	4/28	you can tell yourself

Past trauma relates to emotional eating		
Sense of shame regarding past life events	4/3, 4/8	I don't really like to spread it around town what has happened to me

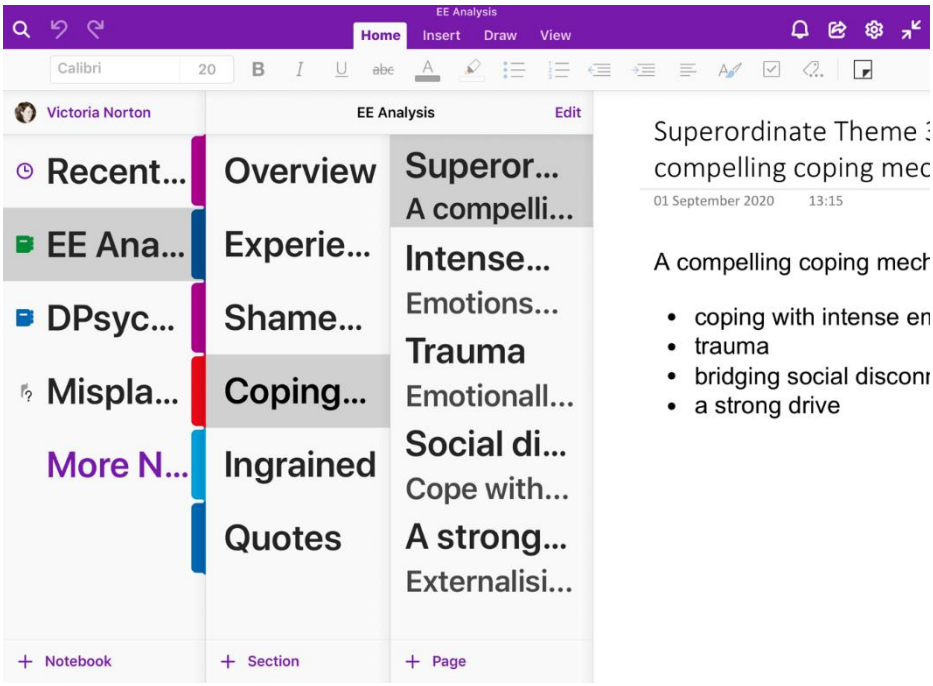
		I felt weak
Events from the past relate to and are a 'big part' of the EE now	4/14-4/15	what I've been through is a big part of it and with the eating
Explaining background and emotional eating to new therapist feels a 'rigmarole'	3/22	will have to go through the whole rigmarole of going through it again

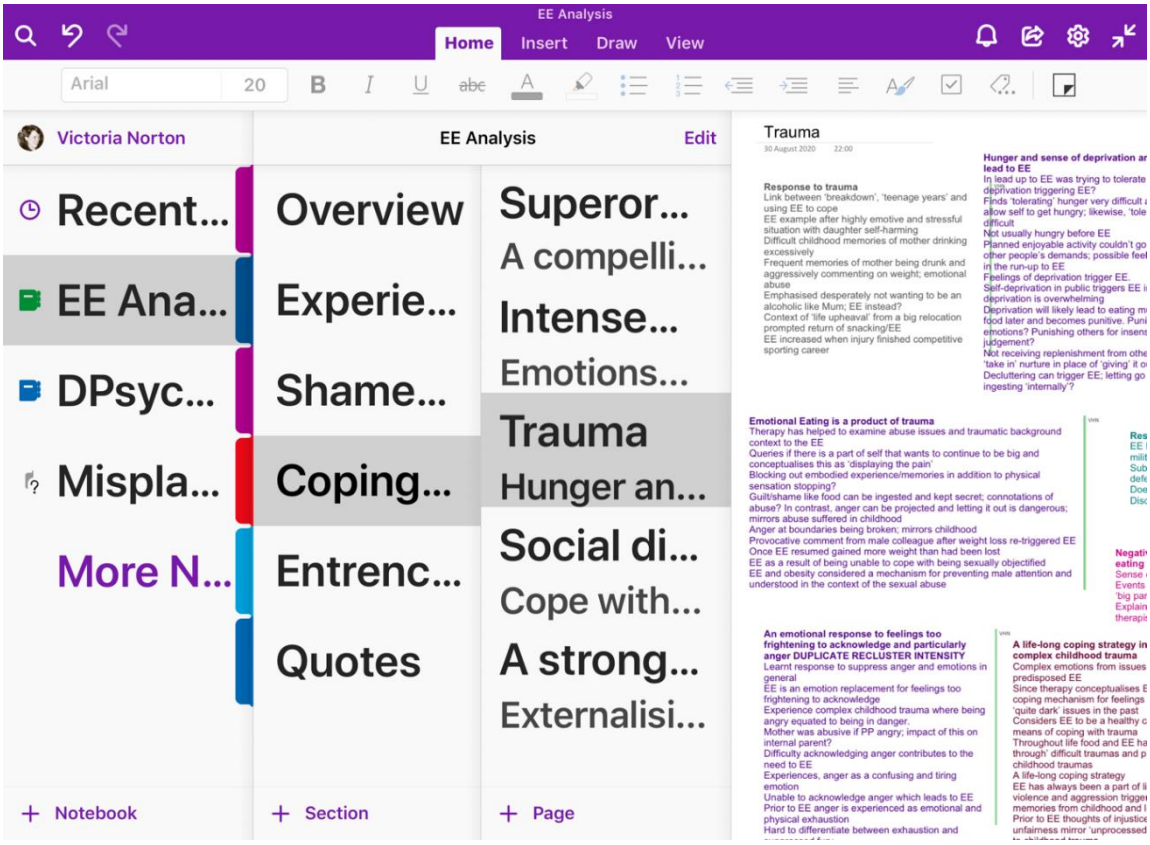
Finding an understanding of EE		
Seeking 'professional' support has been helpful in understanding EE	3/2-4, 3/18, 4/15, 5/1	helped me understand a lot so I have a bit more of an understanding I didn't think talking to a counsellor about it would help but it has done I take help from my therapist
Tries to understand and help family to understand	2/12	well I explained it to my sisters
Lacks confidence in ability to abstain from EE without therapy	3/20	I have self-referred myself for counselling again because I feel that I'm not quite able enough to stand on my own two feet just yet

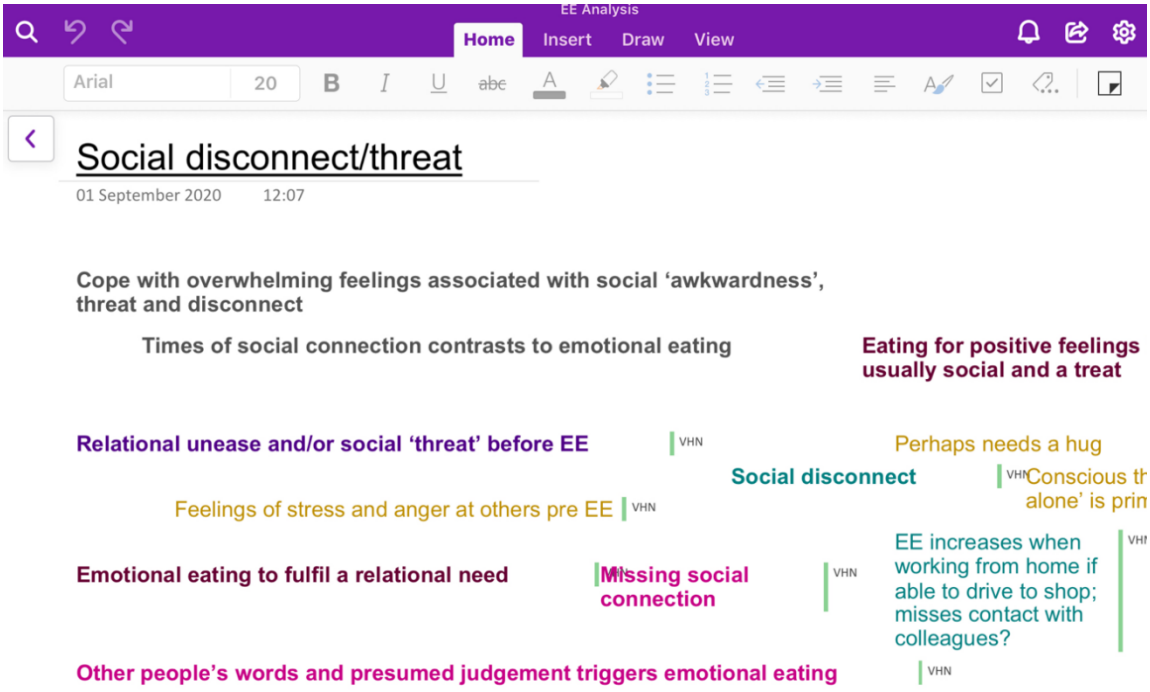
Emotional eating considered a 'bad habit' and compared to addictions		
EE is a bad habit that is hard to break	3/1, 3/11,	it's very hard to break the habit
EE is comparable to smoking, gambling or drinking	3/12-13	like for some people it's smoking or gambling or drinking

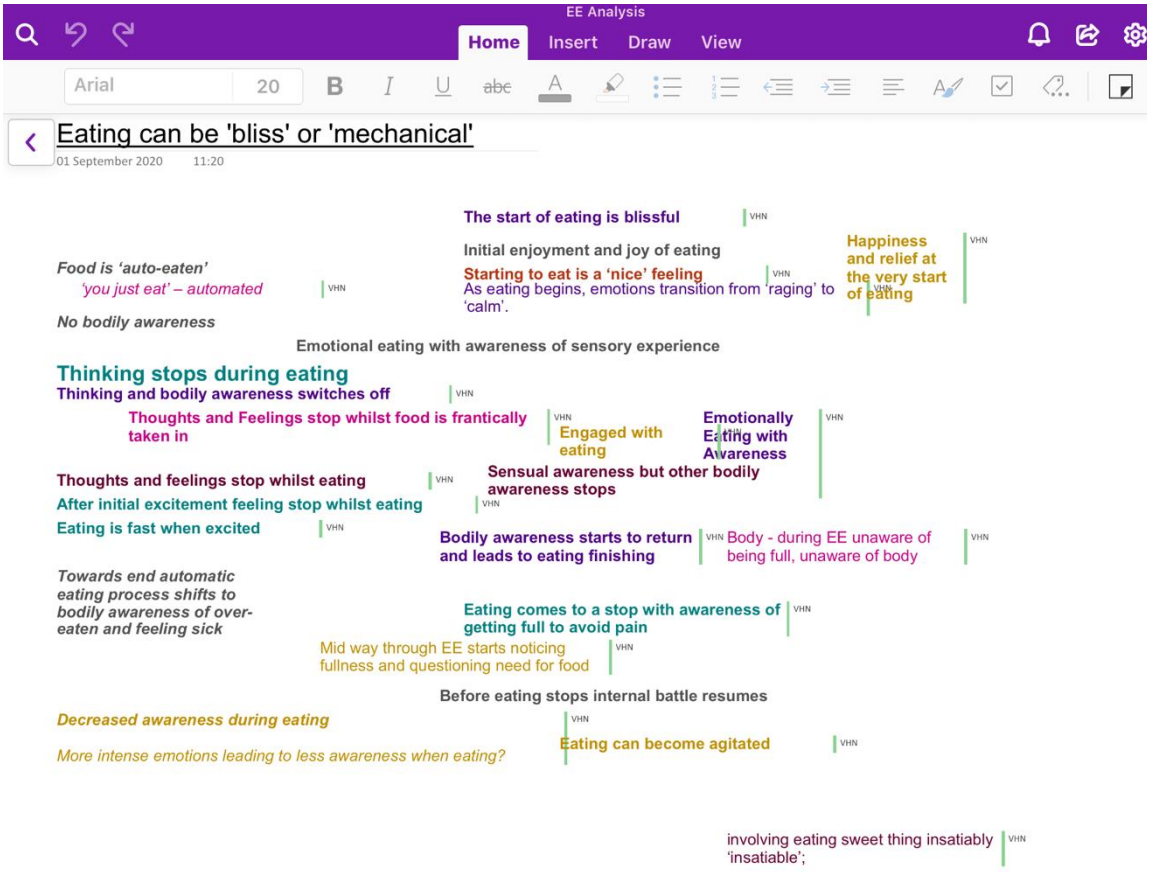
Appendix T:

Sample of screen shots illustrating use of Microsoft OneNote to co-ordinate cross case analysis






EE Analysis
Home
Insert
Draw
View
Arial
20
Social disconnect/threat
01 September 2020 12:07
Cope with overwhelming feelings associated with social 'awkwardness', threat and disconnect
Times of social connection contrasts to emotional eating
Eating for positive feelings usually social and a treat
Relational unease and/or social 'threat' before EE
VHN
Perhaps needs a hug
Social disconnect
VHN
Conscious th
alone' is prin
Feelings of stress and anger at others pre EE
VHN
EE increases when working from home if able to drive to shop; misses contact with colleagues?
VHN
Emotional eating to fulfil a relational need
Missing social connection
VHN
Other people's words and presumed judgement triggers emotional eating
VHN


EE Analysis
Home
Insert
Draw
View
Arial
20
Eating can be 'bliss' or 'mechanical'
01 September 2020 11:20
The start of eating is blissful
VHN
Initial enjoyment and joy of eating
Happiness and relief at the very start of eating
VHN
Food is 'auto-eaten'
'you just eat' – automated
VHN
Starting to eat is a 'nice' feeling
VHN
As eating begins, emotions transition from 'raging' to 'calm'.
No bodily awareness
Emotional eating with awareness of sensory experience
Thinking stops during eating
Thinking and bodily awareness switches off
VHN
Thoughts and Feelings stop whilst food is frantically taken in
VHN
Engaged with eating
Emotionally Eating with Awareness
VHN
Thoughts and feelings stop whilst eating
VHN
Sensual awareness but other bodily awareness stops
After initial excitement feeling stop whilst eating
VHN
Eating is fast when excited
VHN
Bodily awareness starts to return and leads to eating finishing
VHN
Body - during EE unaware of being full, unaware of body
VHN
Towards end automatic eating process shifts to bodily awareness of over-eaten and feeling sick
Eating comes to a stop with awareness of getting full to avoid pain
VHN
Mid way through EE starts noticing fullness and questioning need for food
VHN
Before eating stops internal battle resumes
Decreased awareness during eating
VHN
Eating can become agitated
VHN
More intense emotions leading to less awareness when eating?
involving eating sweet thing insatiably 'insatiable';
VHN

Appendix U: Master table of superordinate and subordinate themes with illustrative quotes across participants

Superordinate Theme A. A spectrum of awareness of dynamic emotions				
Different levels of awareness: from 'engaged' to 'automatic				
Engaged Eating			**Automatic Eating**	
David	the conscious one	4/3	it's the 'you've just got there'… you've not thought about eating, you've just looked and thought 'oh, gosh well I've finished that'	2/9-11
Iris	you can go 'aah' and that feeling of my mouth being full, and it has to be really full as well, you can't just eat one chocolate button	19/10-12	it is always high sugar foods […] because they are the ones that 'numb me out'	15/20
Tish	well I feel nice at the time that I'm doing it because it tastes nice	13/1-2	I guess it ties in with the food feeling because sometimes when I'm eating, when I'm just eating lots of sweet stuff erm it...(long pause) is like I'm powerless, there but not there… I've forgotten what I was saying…sorry	8/4-7
Todd	food that I haven't had in a long time and I get excited and I tend to eat quickly	9/3-6	no...no I'm not feeling, that's the numbness I'm talking about […] it's just like a function	6/4-6
Nicole	I like it too be sugary and fizzy and sizzling on my tongue	6/14-16	during it, I didn't feel or think anything, erm, it just was, I was just eating	5/10-11
Ellaine	I felt, it made me feel better at the time	17/27	sometimes you just don't realise you are eating until you've actually stopped	5/22-23
Before eating: from 'sod it, i'll eat' to 'food is just there'				
Engaged Eating			**Automatic Eating**	
David	the slightest little thing that goes wrong can kick you off into the negative, going towards the	7/26-29	you've not thought beforehand about eating, you've just looked after and thought 'oh…'	2/9-11

	chocolate bar 'ooh this and ooh this' and it's just trying to get you and you think 'oooh, that will make me feel a bit better'			
Iris	you know, I just feel too overwhelmed by all of this	27/29		
Tish	it's the ritual of thinking 'ok, what am I going to have to eat…' 'what shall I do preparing it?'…enjoying the preparation	26/12-14		
Todd	so I think 'ooo, I'll eat some of that' or 'ah that will make me feel better'	5/2-3	they'd be times when I'd not consciously thought about it	17/20-21
Nicole	I just thought I feel so low and alone and well 'sod it' really	1/18-19	sometimes when I don't even realise what it is but I'm not feeling good and the food is there so I just eat	2/13-15
Ellaine	how you are feeling at the time you just sort of look at it and go 'if I eat that, that's going to make me feel better'	2/3-4	or 'that emails really peed me off' and I find myself on the hunt for something	11/9-10

Eating: 'bliss' or 'mechanical'				
	Engaged Eating		**Automatic Eating**	
David	your tongue feels alive, you feel joy, and you actually can do	20/13	but this time, you know, it was more mechanical	14/5-7
Iris	the overwhelming feeling is this is blissful	19/5	my body, everything, is like, gone…there is no sense of anything	20/7-11
Tish	well I feel nice at the time that I'm doing it because it tastes nice	9/8	I think the eating takes away the thoughts […] there but not there	8/24-27
Todd	yes, it's about the happiness, it's about the joy...I think that's what I'm	14/14	that's the numbness I'm talking about…it's just like a function.	6/4

	continually trying to find			
Nicole	my favourite, I like the fizziness	6/16-17	you just eat until you feel that…you don't even register that your full	2/16-17
Ellaine	I suppose the first sort of few mouthfuls are a bit like 'yes, this is good' and you kind of feel relived, sort of happy	4-11/12	I sort of think 'I must have eaten them and I didn't realise I was doing it'	11/1-2
After Eating: disappointment and regret				
David	I really didn't need that did I, I could have done with something, you know, a smaller bar of chocolate, oh why did I eat that?' Then you go through the whole process of kicking yourself			3/20-23
Iris	shit I've done it again, you know this is hopeless I'm never going to be any different and especially when you get to my age			21/9-11
Tish	I think I often feel disappointed with myself…like I've let myself down in some way			12/13-15
Todd	I'm disappointed because I'm not getting the feelings, I was hoping to get			2/3-4
Nicole	erm and I (pause) bollocked myself for doing it, it was a moment of weakness.			8/20-22
Ellaine	afterwards I think 'what the hell have I just done, what have I done that for?'			5/17-19
2. The 'stuck' self experienced within shame fuelled cycles				
The self steeped in secrecy, guilt and shame				
David	well I feel guilty about that, yes… [eating in secret]			15/27
Iris	I mean, look at the size of you, you don't have to be blooming Sherlock Holmes to work out, but it was this shame and embarrassment			26/4-5
Tish	I'm usually on my own...so, I prefer to eat alone emotionally, I feel guilty with other people I think			13/2-4
Todd	I still do it now but not to the extent as in them days when I'd eat in secret			19/3-4
Nicole	and then as I had finished whatever it was that I was eating, I would feel shame			5/16-17
Ellaine	I don't want them to see what I'm eating or anything so I'm quite happy to just hide myself at home…			14/20-21
Self-concept and emotional eating				
David	you're thinking 'oh you're off aren't you', and you've said something wrong and 'why do you always do that'?			6/20-22
Iris	I kind of see, you know, this other side of me when this is going on […] there's a toddler having a tantrum that she wants this chocolate and she wants it now and this hopeless parent trying to say no			17/11-18

Tish	yeah that often happens after eating and I don't like that feeling and then I don't like the way I feel and then I don't like myself in those moments, you know, that I've, like I said, I feel like I've let myself down	13/20-24
Todd	I've had therapists who've been in tears after an hour with me (laughs). That's how screwed up I am.	19/20-21
Nicole	I'm not quite able enough to stand on my own two feet	3/20-21
Ellaine	right now, there is nothing I really like about myself, and that's all down to food because of me eating the wrong types of food and just stuffing myself with it because I feel crap	7/7-10
An emotionally vicious circle		
David	I do bully myself and then I fell really down about that and the first thing I'm going to do is eat chocolate which then gives me another opportunity to then bully myself.	4/9-12
Iris	It's you know, a vicious circle […] and there is this backwards and forwards exhaustion process	17/19-20
Tish	it goes round and round and round	13/26
Todd	and now the depression or my feelings drives the eating and that then drives the depression	2/13-14
Nicole	it's just a vicious circle going around…erm, trying to make you feel better	5/27-28
Ellaine	then I don't lose the weight and that then is when I go back to eating crap, then I feel crap (slight laugh) and it's one big vicious circle	18/7-9
Emotional eating and the obesity spiral		
David	I started thinking then and internalising and beating myself up for things and eating more [...], and it snowballed and snowballed and snowballed and snowballed and got worse and worse and worse…	23/10-14
Iris	I immediately put weight on, because as soon as I try to lose weight that triggers eating	5/2-3
Tish	I think it affects every aspect of my life, actually, and I think for me they are probably entwined…emotional eating and obesity	21/23-25
Todd	I think they are linked…I think that's one of the problems and why I've had obesity	10/10-11
Nicole	this was the way that my weight went and…it got me more down and so I'd eat again and I think the fact that every week I was basically putting on quite a lot of weight was hard for me	6/25-27
Ellaine	for me being obese is linked to my emotional eating because I just fill myself with a load of crap when I feel bad	8/16-18
3. A Compelling Coping Mechanism		
Intense Emotions		
David	I think it's that… (sigh) for me it's just a case of those feelings of 'not being able to', you know, either getting	17/6-10

	angry, getting depressed or getting all…it's all emotion that I'm dealing with by eating chocolate or whatever	
Iris	If I unpick it backwards, there is probably anger again and I think my eating, yeah… any strong emotion will trigger wanting to eat	11/2-9
Tish	I think it means eating my feelings. I actually, when I have strong emotions	1/7
Todd	I think it's a need to satisfy a feeling, yeah, it's a very strong drive	11/1-2
Nicole	when I don't even realise what it is, but I'm not feeling good	2/13-15
Ellaine	If I'm… you know…been really upset by something or really angry about something, that's when I tend to just eat	5/22-25
Trauma and Emotional Abuse		
David	so a lot of my childhood memories with her was, you know, being lovely, lovely, lovely, lovely at school and then coming home and well it was a bottle of whiskey a night sort of thing. Sometimes she'd be fine and sometimes she'd be aggressive and that was her. 'look at this… look, I've done this, what have you amounted to?' she would get quite drunk and aggressive and shout 'you need to lose weight, why don't you just eat less?'	26/17-23 29/28-29 27/22
Iris	my issues around eating were triggered by being sexually abused	33/8
Tish	it's so deeply, you know, it was so deeply traumatic, a whole series of traumas that, erm, I've had to have coping methods like eating	22/29
Todd	It [the emotional eating] became more obvious when…well with all that went on and the safety stuff…it was traumatic	2/9-12
Nicole	I don't really like to spread it around town what has happened to me, especially because my family lives in town with me…what I've been through is a big part of it and with the eating	4/13-15
Ellaine	whenever I jumped in the swimming pool or what have you, my step Dad used to call me Shermoon, 'look out here comes Shermoon' and Shermoon became a thing that really affected me	7/25-27
Bridges social disconnect and/or threat		
David	so when I'd snapped and I was thinking 'oh my God I shouldn't have said something in front of the kids' and I was just urgh. So […] at lunchtime and I sat there and I thought 'ok, I've eaten my packed lunch but I still need to find something else now to eat	9/20-25

Iris	I can't cope with all of these people wanting me, I can't manage this anymore; they all want a bit of me, I'm giving everything I've got and it's not enough, and I'm desperately you know, I keep giving and keep giving, keep giving and it's still not enough, they still want more, and I'm empty.	8/24-29
Tish	I've yet to find anything that replaces that friend.	26/6-7
Todd	yeah, well we still talk and contact each other on skype and whatsapp and that and I do have the facility for skype for business, so I can actually physically talk to people. It's not quite the same though and it is making me eat more	12/1-6
Nicole	I saw my sister last…the day after her birthday and erm…and then we went into lockdown and that's it….and I think, just…I just felt alone	1/21-23
Ellaine	I've been crying or what have you, then yeah sometimes just having a hug or what have you is what I really need rather than the food	12/25-28
A strong drive comparable to addiction		
David	I just think it's addiction […] I think the whole family has suffered from addictions and eating has been part of that addiction	37/25-28
Iris	I think that this whole thing of you know, like addicts…of kidding yourself, playing silly games of, you know, enabling	26/26-29
Tish	I mean obviously it is some form of compulsion…addiction, whatever you want to call it…	3/6-10
Todd	it's just the thing I go to…it's either that or alcohol	13/8
Nicole	a bad habit…like for some people it's smoking or gambling or drinking and it's what I've got used	3/11
Ellaine	I always think of it as somebody who is smoking, when they feel a bit stressed, they go and have a cigarette, if I feel a little bit like that, I go and have food	2/6-8
4. An ingrained and frequently misunderstood phenomenon		
Emotional eating is entrenched		
David	yes and that was linked a lot with probably my teenage years	17/18-20
Iris	I've battled my whole life trying to find a way really to…an alternative way of dealing with these emotions, but, you know, how else do I cope with things?	21/27-29
Tish	I think I have done that a bit…I have used food in that way my entire childhood…entire life...even back to before I was verbal	10/25-28
Todd	when I was very young and I had a meal, you weren't allowed to get down from the table until you had finished and I spent many hours sitting at the table with a cold dinner	1/20-23
Nicole	it's very hard to break the habit	3/1

Ellaine	I have done slimming world…erm, first time, when was it…twelve years ago?...erm and I did lose three stone and I was really really good erm but I then…oh, what happened, something always happens and brings the emotional eating back	16/8-11
Untangling the 'tangle'		
David	you know when you've got that in the background, constantly, just something else can knock the Jenga blocks... and you know the Jenga blocks are falling down. so, I'm sitting there [in therapy session] thinking, if I lose weight, then it's less Jenga blocks that are missing because it can just take one to fall apart	35/13-18
Iris	I would say to anybody…'there is a reason why you do it'…it's been helpful to unpick it in psychotherapy, I found out a lot about why I did it	28/13-16
Tish	I think…well it certainly helps doesn't it?...it certainly helps to understand what your feeling and why you are feeling and what motivates you	22/24
Todd	I think that's what the problem is, that I've lost my drive…when I had the drive…er, the emotional eating was a lesser…a lesser thing because I had the drive not to do it, now I've lost that and the emotional eating has taken over	17/8-11
Nicole	it's very hard to break the habit...I mean, I was…I was lucky…erm, I really can't thank my counsellor enough, they really have helped me understand a lot...so I have a bit more of an understanding	3/1-4
Ellaine	you know that can help with the emotional eating…the psychologist, counselling and stuff like that	12/27
Misunderstanding and Stigma		
David	I think it's almost impossible to be able to explain it in a way that other people understand it	26/12
Iris	when he started talking to me about calories, you know quoting this calories and that, erm, I said I know that…and I think he was actually quite shocked. I always find that when I meet people for the first time, they often think that I'm, you know, unintelligent	23/1-13
Tish	I just couldn't stop. Erm, and I used to think 'why don't I have the willpower?' because I have a lot of will power and of course it's not about willpower	2/2-3
Todd	I think it does get to her a bit when I do the emotional eating, she doesn't really get it…we do talk about it…it's generally one sided but we do talk about it	12/16-18
Nicole	I'd get better about myself…and then I'd see someone else and they'd say something else and erm…and then I would go home and I would eat to make myself feel better again	6/24-25

Ellaine	well no, you've done it because you wanted a packet of crisps, I've done it because I wanted to feel happy so that's why I start eating	9/11-14

Section B.

Journal manuscript suitable for publication

Written in accordance with the author guidelines of the peer-reviewed journal *Clinical Obesity.*

Overview:

1. Manuscript
2. Author Guidelines

Section C.

Professional Component

Compassionate Bite by Compassionate Bite.

A pluralistic clinical case study supporting a client with food neophobia.