

HOW WOMEN EXPERIENCE BINGE EATING – AN IPA STUDY

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Abstract

Binge eating disorder (BED) is the most common eating disorder and women experience it disproportionately to men. BED is associated with a host of negative comorbid physical and mental health conditions. Although there is a strong literature base around the area of eating disorders, BED is under researched; in particular, there is an absence of research looking at how participants experience BED. In the current study six women, who met diagnostic criteria for BED, were interviewed and the resulting transcripts were qualitatively analysed using Interpretative Phenomenological Analysis (IPA). The analysis suggests that the women understand their bingeing behaviour as being a response to transitory experiences of negative affect, but their accounts also implicated a history of food control in childhood, and a sense of social surveillance around their eating behaviours. The analysis also suggests the existence of maintenance factors for bingeing, namely participants' experience of the pleasures of bingeing, and their visceral sense of being powerless to stop a binge. Further, the participants' accounts suggest that while bingeing functioned as a way to (temporarily) alleviate negative affect and to 'rebel' against a history of food control, that binges ultimately further increased negative affect and the sense of being out of control around food. Across the data, it was also notable that while the participants showed some understanding of their bingeing behaviour, overall, their understanding seemed partial and superficial. While their accounts suggest that binge eating behaviour spans different levels of explanation - individual psychological, relational and social - a coherent and convincing understanding of why they binge eat is missing. These results are discussed in terms of the existing theory and research on BED and implications for practice are considered.

Keywords: binge eating, stigma, qualitative, IPA, counselling psychology, eating disorder

Chapter 1: Introduction

This research seeks to create new knowledge in an area which has been previously under researched – how women make sense of and experience the binge process in binge eating disorder (BED). It is envisaged and hoped that this study will contribute to the literature on BED, an eating disorder that has serious interpersonal and health implications and about which little is known. Knowledge of the conditions and circumstances that contribute to BED can help create effective and meaningful treatments for women with this disorder and thus inform the practice of psychologists, counsellors, nurses, doctors and other practitioners working with this population. Since existing research in eating disorders has been criticised for not focusing enough on the experiences of individuals (Berkman, Lohr & Bulik, 2007), it is thought a study of this nature would be a welcome addition to the literature base. This study uses qualitative phenomenological methodology to illuminate women's experiences of living with BED, and by doing so, the project will contribute to the counselling psychology literature base by shedding light on the specific experiences, behaviours and feelings of women with BED.

This research may also contribute to raising professionals' awareness outside of the more specialist services of counselling psychology and eating disorders by crossing over to medical practitioners treating conditions such as 'obesity', diabetes and medical conditions known to be linked with BED. Given the increasing prevalence of BED (Hudson, Hiripi, Pope & Kessler, 2007) and strong links to other conditions such as 'obesity' (Wilson, Grilo & Vitousek, 2007), research, which is not framed in the medical model and can shed light on how the individual experiences the condition, should make a relevant and much needed contribution to the field. Since BED has been included as a full category in the newest edition of the influential Diagnostic and Statistical Manual-5 (5th ed., DSM-5; American Psychiatric Association [APA], 2013) a widely used tool in psychology and psychiatry published in 2013, making new and unique contributions to the literature base is essential. More

recently, Public Health England have issued guidelines, 'All Our Health' (Department of Health, 2018), highlighting the need for all health care professionals to be able to discuss 'obesity', given the connection with both an individual's physical and mental health. Projects that aim to explore both interconnected issues seem highly relevant and in line with current policy, especially given that the majority of the literature on BED is driven by the medical model philosophy and neglects the individual's inner world. Having a better understanding of the lived experience and inner world of individuals with BED might help clinicians, across various disciplines, build trust, establish mutual respect and develop a therapeutic alliance and/or professional relationship that will serve as the basis for ongoing explorations and treatment of problems associated with binge eating.

In sum, little is known about BED and how women with this condition experience, manage and recover from this eating disorder. The purpose of this study is to examine how women with BED experience and understand binge eating. A qualitative methodology, IPA, was chosen as the project is designed to illuminate women's phenomenological experiences. It was also felt that Interpretative Phenomenological Analysis (IPA) would help answer the research question 'How women experience binge eating?'

Chapter 2: Literature Review

The following literature review presents a critical overview of the theoretical and empirical literature on BED. The literature review will encompass: definitions of BED, epidemiology, relationship to obesity, psychological co-morbidity, diagnostic considerations and risk factors. Following this, the paper will explore theoretical models followed by a summary of relevant qualitative studies. While this literature review is comprehensive, currently research that specifically explores the lived experience of binge eating disorder is limited. The following review seeks to justify this study, a qualitative exploration of the experiences of women meeting criteria for BED.

What is Binge Eating Disorder?

While BED is a relatively new concept in eating disorders (only formally a diagnosis from DSM-5), socially sanctioned binge eating is a historical fact. Like bulimia, binge eating can be traced back over two millennia to Roman times during which ‘vomitoriums’ were constructed to allow participants to binge, purge and then return to the table to continue eating (Touyz, Polivy & Hay, 2008). Binge eating is not just historical, it is common place: It would be hard to overlook the bingeing component in religious ceremonies such as Christmas and Ramadan, which is known for its month long, daily fast/binge cycle. Thanksgiving, a non-religious holiday celebrated in North America, is also seen as a day of collective gastric gluttony.

This point, that binge eating is a behaviour that in certain current and historical social contexts is ‘normal’, is made to position the following which illustrates the evolution of binge eating as a ‘disorder’. It was half a century ago, in 1959 that Stunkard first used the term “*binge eating*” in an academic setting to describe an obese population (Stunkard, 1959; 1976). References to binge eating ‘disorder’ however did not appear in the literature until the early 1990s, when there began to be discussions about its inclusion in the Diagnostic and Statistical Manual of Mental Disorders-IV (4th ed.; DSM-IV; American

Psychiatric Association, 1994) as a new diagnostic category to depict individuals who engage in recurrent episodes of binge eating without utilising the compensatory mechanisms, characteristically seen in bulimia nervosa, such as vomiting and excessive use of laxatives. Spitzer et al., (1992) conducted the first multisite study on BED, which pointed towards the potential usefulness of BED as a separate diagnosis for clinical and research purposes. However BED was not introduced as a stand-alone diagnostic criteria in the DSM IV, instead it was included under the catch all “*eating disorder not otherwise specified*” (ED-NOS), a residual diagnostic category reserved for those eating disorders of clinical severity other than anorexia nervosa (AN) and bulimia nervosa (BN) (American Psychiatric Association, 1994). However, BED was identified as a stand-alone category for research purposes (Cooper, Fairburn & Hawker, 2003).

In the May 2013 publication of the DSM-5, BED was given a fully-fledged diagnostic category along with AN and BN (APA, 2013). In this context, BED was defined as eating, in a discrete period of time, a more than ‘normal’ amount of food, considering the context, and experiencing a lack of control during the binge episode (APA, 2013, p. 550). The DSM-5 criteria also added that three out of five of the following must be met:

- Eating faster than usual
- Eating until uncomfortably full
- Eating large amounts of food when not physically hungry
- Eating alone because of embarrassment by how much one is eating
- Feeling disgusted with oneself, depressed or very guilty after overeating

In addition, “*the binge eating must occur on average at least one day a week for three months and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa*’ and causes “*marked distress*” (APA, 2013, p731). It should be noted that the only change in diagnostic criteria between the DSM-IV and 5 is binge frequency. The frequency criteria was reduced from binge eating “*must occur on average at least two days a week for six*

months” in the DSM IV to the current “one day a week for three months” (APA, 2013).

One other key diagnostic feature of note is that during the binge episode an individual must experience both a loss of control and marked distress. The experience of ‘*loss of control*’ during a binge episode may be associated with the person eating either an objectively large (what most people would consider large) amount of food or subjectively large amount of food, e.g. a small to moderate amount of food that is considered large by the individual. Moreover, it is theorised that the experience of psychological distress associated with bingeing is dictated not by the type or quantity of food consumed but by the experience of feeling “*out of control*” (Pollert et al., 2013).

The DSM-5 has also added levels of severity to the diagnosis of BED. Clinicians are given a spectrum ranging from mild (one to three binges per week) to extreme (14 or more binge eating episodes per week) (APA, 2013).

(For full DSM-5 criteria of BED, please see Appendix A).

Debate around diagnosis

There was a contentious debate surrounding the definition of BED, and whether it is a stand-alone diagnostic category (Wilfley, Wilson & Agras, 2003; Wilfley, Bishop, Wilson & Agras, 2007). The debate centred around two key questions: (1) Is BED a “*syndrome of clinical significance*” (Wilfley et al., 2003, p.596) that is separate from other eating disorders, such as Bulimia and Anorexia? and (2) is it beneficial to have more or less diagnostic criteria for mental health care providers?

Prior to the release of the DSM-5, the main argument against the inclusion of BED as a separate diagnostic category was centred around the fact that, at that point, too little was known about BED (Fairburn, Welch & Hay, 1993) and there was a lack of evidence to suggest that the diagnosis of BED would be useful in predicting treatment selection, prognosis or outcome (Pincus, Frances, Davis, First & Widiger, 1992). Those who argued for the clinical value of inclusion of BED include Spitzer et al. (1991; 1992). Others

have questioned whether BED is a ‘disorder’ or whether it is normal eating behaviour that has been influenced socially, culturally or by class or gender (Orbach, 1978; Heenan, 2005).

Opponents of the inclusion of BED in the DSM-5 also tended to focus their argument on the issues they speculated would arise as a result of its inclusion. Primarily, there were concerns that inclusion in the DSM-5 would result in unnecessary labelling of individuals, which can be detrimental and result in stigmatisation (Treasure & Schmidt, 2001), would lead to the trivialisation of BED as a mental disorder (Fairburn et al., 1993) and that it would create a platform for psychiatric and pharmaceutical entities to capitalise on and take advantage of (Healy, 2009). Proponents in this camp were also often part of a larger group who questioned the reliability and validity of the entire DSM categorical system regarding eating disorders with suggestions that the DSM had not been subjected to enough analysis (Clark, Watson & Reynolds, 1995; Kreuger & Piasecki, 2002). Other critics also took issue with the fact that the DSM aligns with the medical model, a reductionist approach, and fails to account for the phenomenological experience of the individual (Waller, 1993).

Stance on diagnosis in this thesis

In the current work, the criticisms around the diagnosis of BED are acknowledged. As one critic of diagnosis puts it, “*Psychiatric diagnosis is based on social not medical judgement*” about what is “*normal*” behaviour or experience (Johnstone, 2014, p32). These types of concerns promoted a wave of criticism when DSM-5 was published, including a statement from the British Psychological Society that raised concerns about the stigmatising impact of medical labels being applied to behaviour that is part of a spectrum of normal human experience. In the current work, the socio-cultural influences on BED are acknowledged, as is the potential for pathologization of individuals through the BED diagnostic label. Nonetheless, the diagnostic term is utilised because, despite concerns, BED is now an established diagnosis and it is a category that is being used to frame understanding of individuals who present

in clinical and broader medical (e.g. bariatric) settings. Using the term BED allows this research to speak to others doing work in this area and thus potentially impact on broader academic understandings of BED and influence treatment models. However, while this study will pragmatically use the diagnostic label, in the spirit of counselling psychology, there will also be an effort to understand and honour the unique experience of the individuals who participated in this study, with the aim of balancing the pragmatic use of diagnostic terminology – a useful but crude commonly understood shorthand – with a commitment to placing the client experience, specifically their self-experience, at the centre of not only practice but also research.

Epidemiology

Epidemiological research concerning BED has not progressed far with data almost exclusively focusing on Western countries (Striegel-Moore & Franko, 2003). Furthermore, as studies are based on a range of differing definitions of BED and data gathering methodologies, cross study comparisons are challenging (Smink, van Hoeken & Hoek, 2012). Incidence and frequency rates acquired from various studies show considerable variability, depending on the particular population surveyed, resulting in generalisation problems (Crossrow et al., 2016). BED is estimated to occur in 2% - 4% of the general population (Hayes & Napolitano, 2012) 8 - 10% of obese individuals (Wilson et al., 2007), and 40% of individuals seeking weight loss treatment such as bariatric surgery (Gianini, White & Masheb, 2013). Furthermore, Kessler et al., (2013) using interview-based diagnostic classification data from the World Health Organization Mental Health Survey Initiative, estimated that lifetime prevalence of BED is 2% across the countries included in the survey. Using the same data, they also estimated age of onset ranges from late adolescence to early 20s (Kessler et al., 2013). BED also appears to be twice as prevalent as BN and nearly five times more prevalent than AN (NICE, 2017; Wonderlich, Gordon, Mitchell, Crosby & Engel, 2009).

Gender differences are present in the prevalence of eating disorders with significantly higher rates in women compared to men, with women

outnumbering men by approximately 95% to 5% respectively (Button, Aldridge & Palmer, 2008). In BED, while the gender gap is less pronounced, the female-to-male ratio is still approximately three to one (Cossrow et al., 2016; Hudson et al., 2007; Guerdjikova, Mori, Casuto & McElroy, 2017). Women also tend to engage in more frequent, severe and impairing episodes of bingeing behaviour (Barry, Grilo & Masheb, 2002; Roehrig, Masheb, White & Grillo, 2009). Equally, evidence would suggest that women with BED experience more body image dissatisfaction as well as negative emotions than men and are more likely to binge in response to negative emotions than men, whereas men are less likely to report distress over binge eating (Mitchell, Delvin, de Zwaan, Crow & Peterson, 2008). Differences related to sex roles and cultural factors have been suggested as an explanation for differential diagnosis rates between the sexes (Barry et al., 2002).

There is a limited body of research, mainly concentrated in the USA, looking at ethnic group differences in BED which broadly suggests that cultural expectations around body shape, size and weight plays a role in BED frequency and clinical presentation in particular populations (Bennett & Dodge, 2007; Franko, Lovering & Thompson-Brenner, 2013; Pike, Dohm, Striegel-Moore, Wilfley & Fairburn, 2001; Smolak & Striegel-Moore, 2001).

From the preceding statements, two things are noteworthy; the epidemiological data to date suggest, (1) that BED is a 'disorder' that is common, particularly in women, and (2), that BED prevalence is impacted by socio-cultural factors. These two conclusions should be held in mind considering the debate over BED as a diagnosis.

BED and Obesity

The significance of an overlap between BED and obesity emerges from a context in which obesity is currently being framed as a global health challenge. For example, according to NICE (2006, p.2), "*obesity is the most serious threat to the future health of our nation*" and urgent action is being called for to stem the rise. Besides correlations between obesity and many

serious, potentially life-threatening physical conditions (NICE, 2006), there are also psychological concerns associated with obesity, especially in terms of quality of life and feelings of wellbeing (Agh et al., 2015; Kushner & Foster, 2000; Ramacciotti et al., 2008).

Binge eating is associated with obesity (Masheb & Grilo, 2000) check if this is the first one Hudson et al., 2007; Iacovino, Gredysa, Altman, & Wilfley, 2012; however the prevalence of BED among the obese is unclear since rates vary from study to study. Epidemiological studies on BED have shown that about 50% of those who meet diagnostic criteria for BED are also 'obese' (Public Health England, 2018). Gianni, White and Masheb (2013) estimate BED affects approximately 8% to 20% of obese individuals while Dingemans, de Jonge and van Furth (2005) suggest the figure ranges from 1.3 to 30.1%. Other research suggests that obese individuals have a substantially higher lifetime occurrence rate of BED than the general population (Marcus & Wides, 2014). In obese individuals seeking weight loss treatment, the prevalence rates co-occurring BED are estimated to be 30-50% (de Zwann et al., 2005; Vinai et al., 2016). Overall the data suggests an overlap between those who meet diagnostic criteria for BED and obesity, particularly for those individuals who are actively seeking weight loss treatment.

Overlap between BED and obesity is of relevance to the current study for two reasons: (1), widespread cultural and medical concern about increases in obesity rates in the population generally suggest a value in better understanding a condition associated with obesity and (2), the commonplace nature of concerns around obesity logically has a personal impact on those with BED who are also heavier.

Obesity is typically defined in terms of body mass index (BMI), a number achieved by dividing weight by height squared; under current definitions, BMIs over 30 are considered 'obese'. In the UK obesity rates are rising; currently approximately 25% of the UK population is considered obese (Baker, 2018). Women and men are "obese" at generally the same rate (though

slightly more men are “*overweight*” (Baker, 2018), however, for women but not for men, obesity prevalence varies with area deprivation. In the most deprived areas of the UK the prevalence of female obesity is almost double that of men (NHS Statistics Team, 2018, April), which suggests the potential influence environmental or cultural factors have on weight for women.

It is important to highlight that BED and obesity are not synonymous. Obesity is not a criterion for BED and vice versa. Moreover, research suggests differences between obese individuals who meet criteria for BED and those who do not (e.g. Castiglioni, Pepe, Gandino & Veronese, 2013; Ivezaj, White & Grillo, 2016; Klatzkin, Gaffney, Cyrus, Bigus & Brownley, 2015; Schag, Schonleber, Teufel, Zipfel & Giel, 2013).

It has also been suggested that BED may operate differently for obese and non-obese individuals (Dingemans & van Furth, 2012; Goldschmidt, Tanofsky & Wilfley, 2011; Nicholls, Devonport & Blake, 2016). Despite this, it is important to consider the role of obesity in the current study because of the dominance of the cultural discourse around the ‘obesity epidemic’.

One consequence of the cultural focus on ‘fat’ is an increasing recognition of the role of weight stigma (Andreyeva, Puhl & Brownell, 2008). Research in this area has documented that obese individuals face stigmatisation across a variety of society settings including healthcare (Puhl et al., 2015). It has been suggested that due to weight bias individuals with obesity receive substandard healthcare and that this explains why they report avoiding healthcare for both physical and mental distress (Puhl & Heuer, 2009). It has also been consistently found that the impact of weight bias is greater for women than men (Fikkan & Rothblum, 2012).

Comorbid conditions

The previous section discussed the overlap between obesity and BED. This section focuses on comorbidity because overlap between psychological diagnostic categories may shed light on etiology.

Research has established that BED is frequently experienced in conjunction with other difficulties (Mitchell et al., 2008; Olguin et al., 2017; Telch & Agras, 1994; Yanovski, Nelson, Dubbert & Spitzer, 1993). As previously mentioned, BED is linked to obesity related health concerns. However, irrespective of size, there are associations between BED and sleep problems, fibromyalgia, irritable bowel syndrome, gastrointestinal problems, asthma and in women, early menarche (Javaras et al., 2008; Johnson, Spitzer & Williams, 2001).

In addition to medical co-morbidity, BED is also linked to emotional distress such as alcohol and drug abuse, problems with work, social functioning and general psychopathology (Striegel-Moore & Bulik 2007). Wilfley et al., (2000) found that 77% of participants with BED were diagnosed with at least one additional lifetime psychiatric disorder: 33% substance abuse, 29% anxiety disorders, 22% mood and 61% with a lifetime mood disorder. Depression, overall, was the most common comorbid diagnosis (Hudson et al., 2007). In addition, research also suggests BED is associated with personality disorders (Telch & Stice, 1998; Wilfley et al., 2000) bipolar disorder and PTSD (Hudson et al, 2007). Despite the clear evidence of significant comorbidity, to date, there is little accepted explanation for the high rates of comorbidity between BED and other psychological disorders. This may relate to a broader lack of agreement about a theory of BED, which is discussed in the next section.

A note about language use

This thesis uses terms such as 'obese', 'obesity' and 'overweight' which are rooted in medical understandings of problematic size/weight for individuals. It is acknowledged that these terms can be experienced as stigmatising and pathologising, in particular for women (Tischner, 2013). Research suggests that clinicians can establish better rapport with heavier patients by attending to the obesity and binge related terms they use (Puhl, Peterson & Luedicke, 2013). Lydecker and Grilo (2016) examined individuals' preferred terms for obesity and binge eating and concluded terms such as

'obese' are not seen as benign medical terms but instead experienced as judgemental and stigmatising. Furthermore, the researchers found that obese women with BED were more sensitive to the clinician's use of language than obese male non-bingers. While it is acknowledged that these terms are not experienced as 'neutral' they are nonetheless used in this thesis for the same pragmatic reasons that diagnostic language and constructs are used; pragmatically the thesis is adopting the language that is used by researchers in the area in order to create the potential that the findings can speak to this discipline area. However, the terminology is not adopted uncritically.

Theoretical Models of BED

In considering the question of BED, evaluation of the theoretical models of BED is critical. The search for an etiological explanation for the development and maintenance of binge eating has fostered widespread debate and little consensus (Polivy & Herman, 1993). Although there is significant literature dedicated to conceptualising AN and BN, studies examining theoretical models specifically for understanding the processes of BED are limited (Burton & Abbott, 2017). In addition, the literature that does question the function of binge eating is usually focused on understanding bingeing in the context of BN. However, BN is associated with cycles of bingeing and restraint and/or compensatory behaviours and these cycles are not found in BED. Thus, theories which seek to explain BN may not generalise to binge eating in BED.

An additional issue is that any one explanatory model of BED is likely to be lacking. Polivy and Herman (1993) see binge eating as "*a complex behavioural pattern*" and warn against using only one theoretical model to understand the etiology of binge eating, further stating "*accounting for it by one single cause is likely to be futile and misleading*" (p. 187). One potential solution is to think about explanatory models more broadly than in terms of purely individual factors. The biopsychosocial model, which was posited as an alternative to a purely biomedical model of illness (Wade & Halligan, 2017) incorporates the idea of explanations at the levels of individual biology,

psychology and society. This model has been used in work on eating disorders (e.g. Rodgers, Paxton & McLean, 2014) and, arguably, offers a more complete understanding of the etiology of a condition such as BED. To date, there has been limited explanation of genetic factors in BED (see Munn-Chernoff et al., 2015; Bulik, Kleiman & Yilmaz, 2016) however, there is a growing neuroscience literature investigating neurobiological explanations for eating behaviours, in particular 'food addiction' (Carter et al., 2016). However, in this thesis the focus falls predominantly on the individual psychology and the social levels of explanation; in addition, 'social' is understood in terms of both the close relational context of a person historically and currently (e.g. family relationships) and in terms of the influence of broader sociocultural factors and understandings.

In the following, key models of BED are discussed. The complex literature on biological and genetic theories of BED is briefly introduced. Models at the level of individual psychology which are introduced include: restraint theory, escape theory, the affective regulation model, the emotion regulation model and addiction theory.

Relational understandings of BED are considered through consideration of systemic and psychodynamic theories of BED, while the sociocultural factors are considered by looking at feminist theory, in particular understandings around female bodies, women and food and women and fat, as these pertain to BED.

Biological and genetic understandings of BED

While to date the research is limited, there are an increasing number of studies suggesting eating disorders, in general, can be heritable and influenced by genetics (Bulik et al., 2016; Kirkpatrick et al., 2017). Most of the research in genetic epidemiology of eating disorders is in family and twin studies. Hudson et al. (2006) found that BED – independent of obesity – occurs more frequently in family members of individuals with BED than in control families. Further, family studies report odds ratios between 1.9 and 2.2 for the risk of

BED in first degree relatives compared with relatives of controls (Jarvaras et al., 2008). Twin studies also show that BED is moderately heritable with rates above 40% (Klump, McGue & Iacono, 2002; Root et al., 2010). However, both the genetic and twin studies research to date have (as yet) limitations. For example, the role of specific genes has been suggested in the development of BED but none has yet been identified and further an understanding of how these genes work is (as yet) limited (Trace, Baker, Peñas-Lledó & Bulik, 2013). As with the family studies, one implication is environmental factors must be considered as also being key in explaining BED.

The potential biological underpinnings of BED have also been suggested by neurobiological research. Neurobiologically, individuals with BED are shown to have increased impulsivity, compulsivity and altered reward sensitivity. Recent studies have shown serotonin might play a modulating role in BED (Kessler et al., 2016). The limited studies in the area also suggest the involvement of both dopamine and u-opioid receptors in the etiology of BED (Davis, 2015). Although the research in this area is still in its infancy, neuroimaging research suggests altered dopamine function is an important contributor to binge eating (Kenny, Voren & Johnson, 2013) and may also contribute to impulsivity, compulsivity and reward/reinforcement which are also seen in other compulsive behaviours such as substance abuse and gambling (Kessler, Hutson, Herman & Potenza, 2016).

Research has also suggested that the dopamine system may be implicated in potentiating what has been termed 'food addiction,' which is understood as a potential key contributory factor in BED (Carter, Van Wijk & Rowsell, 2019). Individuals with a BED diagnosis have been shown to have a predisposition for certain foods – processed, high sugar and fat content – with an abuse potential similar to the overuse of alcohol and cocaine (Davis, 2014). Moreover, it is thought that the dopamine reward system plays a central role in regulating our desire for such foods, with evolutionary biologists suggesting this was an adaptive strategy for survival. Given this, BED can be seen as

arising from a maladaptive gene-environment interaction in food-rich modern environments and conceptualised as an “evolutionary mismatch” (Davis, 2015).

In summary, there is increasing research which suggests genetic and biological explanations for BED. However, none of the research to date suggests that these are the *only* explanatory factors (Trace et al., 2013). In the next section, a number of individual psychological explanations are explored.

Restraint Theory

The restraint model is a partly biological explanation for BED in that it assumes a role for hunger. Intended to explain differences in eating patterns between normal weight and obese individuals, Ruderman (1986) proposed restraint theory. However, it was later found that the theory was more appropriate for explaining binge eating found in eating disorders (Herman & Polivy, 1988). Restraint theory postulates that dieting leads to hunger, which then leads a person to binge (Polivy & Herman, 1993). Additional factors include persistent attempts to control calorie and food intake (Johnson, Pratt & Wardle, 2012) and negative mood, but only when paired with deprivation (Ruderman, 1986).

Empirical support for the restraint model is mixed. Spurrell, Wilfley, Tanofsky and Brownell (1997) found support for restraint theory in binge eating in participants whose dieting behaviour preceded binge eating. However, for those where binge eating precedes dieting, the results did not support the theory (Manwaring et al., 2006; Mussell et al., 1995) and Blackburn, Johnston, Blampied, Popp and Kallen, (2006) found an independence of dietary restraint and binge eating. To help explain the contradictory results of the literature around restraint theory Spurrell et al. (1997) suggest that the influence of restraint on BED may be dependent on the order in which dieting and binge eating occurred. However, this resolution is not unproblematic since one criticism of the restraint model for BED involves the role of dieting: specifically, individuals with BED appear to exhibit significantly fewer dieting behaviours than individuals with other eating

disorders such as BN (Castonguay, Eldredge & Agras, 1995; Ochner, Gray & Brickner, 2009; Santonastaso, Ferrara & Farvaro, 1999; Wilson, Fairburn, Agras, Walsh & Kraemer, 2002). Rather, individuals with BED eating habits tend to follow more of a variable pattern (Masheb & Grilo, 2000; Timmerman, 1998).

In sum, the evidence for this theoretical model of BED is not convincing and restraint theory is criticised for being too narrow of an explanation of binge eating pathology (Waller, 2002).

Escape Theory

While restraint theory presents binge eating as a reaction to restrictive food intake, escape theory views it as an attempt to escape from self-awareness (Heatherton & Baumeister, 1991). This model postulates that binge eaters have unreasonably high expectations for themselves in terms of both self-esteem and body image. When the individual fails to live up to these extremely high standards, irrational thoughts and negative affect (in particular depression and anxiety) emerge. These unpleasant emotions foster even more distress and may cause an individual to attempt to remove troubling thoughts from awareness through cognitive narrowing (Heatherton & Baumeister, 1991). Cognitive narrowing focuses attention to the present and the immediate stimulus environment and as a result avoids meaningful thought and keeps self-awareness at a relatively low level. The avoidance coping strategy of binge eating then occurs as a way to escape from the negative affect emerging (Heatherton & Baumeister, 1991). Additionally, the escape model claims the individual might attribute their negative affect to the binge episode rather than the original source of distress, thus perpetuating the binge cycle long term (Polivy & Herman, 1999).

The empirical evidence for escape theory is limited (Paxton & Diggins, 1997; Rosenbaum & White, 2013). Blackburn et al., (2006) found that perfectionism, negative self-awareness, negative affect and cognitive narrowing each contributed to binge eating and that, although maladaptive,

binge eating provides an important function for the individual. In addition, there is some evidence that BED is associated with experiences of dissociation (Austin, 2013; La Mela, Maglietta, Castellini, Amoroso & Lucarelli, 2010; Moulton, Newman, Power, Swanson & Day, 2015; Palmisano, et al., 2018). This link would suggest that a binge provides 'escape' from negative affect by allowing the individual to dissociate.

As a stand-alone explanation of binge eating, the evidence in support of escape theory is quite limited. Yet, there are similarities between escape theory and other theories proposing binge eating is as a response to negative affect and may provide a way of coping and regulating emotion (Burton & Abbott, 2017).

Affect Regulation Model

The affect regulation model posits binge eating is triggered by and serves to mitigate negative affect. In addition to cueing binge eating, the model also hypothesises that binge eating is maintained through negative reinforcement (when a behaviour, here bingeing, is strengthened because engaging in it avoids a negative outcome, i.e. experience of negative affect; Polivy & Herman, 1993). There is considerable research supporting the first tenet of the affect regulation model, that negative affect plays a role and can trigger binge eating (see Deaver, Miltenberger, Smyth, Meidinger & Crosby, 2003; Haedt-Matt & Keel, 2011; Mason et al., 2017). However, the empirical evidence for the second tenet – that bingeing reduces experience of negative affect – is less clear. Some studies show a decrease in negative affect (Berg et al., 2015; Smyth et al., 2007) while some show an overall increase in negative affect (Haedt-Matt & Keel, 2011). What seems to be emerging from the literature around the affect regulation model for binge eating is that individual affect fluctuations might be dependent on the context of the binge episode; people with BED experience the binge episode differently from bulimics and anorexics (Berg, et al., 2013; Berg et al., 2017). This provides support for the

idea that studies looking at the role of affect during the binge episode, specifically with people who have BED, might be useful. The empirical evidence for the affect regulation model thus is mixed. In addition, the model does not explain why binge eating is selected as the coping mechanism for the BED individuals. Given negative affect is such a broad construct that covers many emotional experiences, it might be useful to explore how emotions are experienced by women with BED during the binge cycle.

Emotional Regulation Theory

The affect regulation model and escape theory theorise that negative mood can trigger a binge in BED. However, as previously highlighted, the vast majority of the research studies in the area are not specific to BED. Further, these theories do not address why people with BED seem to experience relief from negative affect post binge.

Increasing attention is being paid to emotions, and more specifically emotion regulation, across all eating disorders. Fox and Power (2009) claim negative emotions have a central role across all eating disorders; suggesting the eating disorder inhibits the experience of negative emotions.

A newer and broader theory relevant to BED is the Emotional Regulation Theory. This theory posits that an individual with BED will have wide-ranging difficulties in emotion regulation including reduced impulse control, poor emotional awareness and clarity, and lack of emotion control strategies (Kittel, Brauhardt & Hilbert, 2015; Lavender et al., 2015).

Zeeck, Stelzer, Linster, Joos & Hartmann (2011) looked at everyday emotions and the relationship between emotions and the desire to binge eat in women with BED, obesity or normal weight controls. Their study included only women due to the gender specific difference in emotion perception and regulation that has been found (Larsen, van Strien, Eisinga & Engels, 2006; Tanofsky, Wilfley, Spurrell, Welch & Brown, 1997). The women with BED showed a more negative pattern of every-day emotions. In particular, emotions related to interactions with others seemed to be more relevant, such

as feelings of being bored, hurt and disappointed and lonely suggesting “*a lack of satisfaction in life and relationships with others or a selective processing of daily events*” (Zeeck et al., 2011, p. 434). In addition, they concluded that women with BED are more likely to binge eat in response to negative emotions than the other two groups. The negative emotions identified were: feeling angry, hurt, guilty, disappointed or sad.

In conclusion, this theory does not provide a definitive explanation for binge eating. However, it might be relevant in attempting to understand the emotional process of individuals with BED.

Addiction Model

Another influential theoretical model for BED is the addiction model. Parallels have often been drawn between binge eating and addiction, with many researchers suggesting that binge eating might be better thought of as an addiction (e.g. Gold, Frost-Pineda & Jacobs, 2003). Indeed, many binge eaters are thought to share similarities with individuals who have addictive disorders (Cassin & von Ranson, 2007). Loss of control, preoccupation with the substance or food, secrecy from others and use in order to regulate affect are common themes reported by both binge eaters and those with alcohol and drug dependence (Wilson, 1993). According to Wilson (1991), cravings leading to a feeling of loss of control over behaviour, are quite commonly reported in binge eating. These cravings, and not feeling in control, lead to a preoccupation with food, resulting in repeated unsuccessful attempts to stop or control the behaviour (Wilson, 1993). As seen with substance abusers, shame, guilt and other negative psychological and social consequences can occur as a result of their actions (Gold et al., 2003).

Research has shown that some individuals do experience binge eating as being like an addiction (McAleavey & Fiumara, 2001); other research suggests that for some who meet criteria for BED their binge eating meets the DSM IV criteria for addiction as well (Cassin & von Ranson, 2007). Perhaps the most convincing argument to date in favour of the idea of an ‘addiction’ model

of BED is the growing interest in a new diagnosis of “*food addiction*” (Gearhardt, White & Potenza, 2011; Shell & Firmin, 2017). Yet the putative diagnosis of food addiction remains controversial (Finlayson, 2017; Long, Blundell & Finlayson, 2015; Meule, 2015; Ziauddeen & Fletcher, 2013) and correspondingly the value of an Addiction Model for BED remains unclear.

Transdiagnostic Model

The Transdiagnostic Model of Binge Eating (Fairburn, Cooper & Shafran, 2003) suggests all eating disorders, including BED, share the same “core psychopathological processes” and that this is essentially cognitive in nature. The model challenges the need to separate eating disorders into distinct clinical or diagnostic presentations which each require specific treatment. Instead, the transdiagnostic model focuses on the common psychopathology thought to maintain all eating disorders.

What the model sees as being of central importance in the maintenance of any eating disorder is the “core psychopathology” of an individual’s tendency to judge their self-worth largely in terms of shape and weight and their inability to control either (Cooper & Grave, 2017). This overvaluation of weight and shape and perceived lack of control has been found to be present in anorexia, bulimia and BED (Fairbairn et al., 2003). The model also suggests there is a sub-group of patients across all eating disorders who also share the symptoms of low mood, clinical perfectionism, low self-esteem and interpersonal difficulties.

In the transdiagnostic model, bingeing behaviour is mainly thought to be a response to food restriction (Fairbairn et al., 2003). It is suggested bingeing results when the individual finds it impossible to follow strict diets or restrictive food regimes. The bingeing behaviour then maintains the core psychopathology of an individual’s excessive concerns about their weight, shape and control (Cooper & Fairburn, 2011).

There is considerable research which supports the transdiagnostic theory including that it is not uncommon for individuals with an eating

disorder to move between eating order diagnoses (Fairbairn et al., 2003; for an overview of the evidence also see Cooper & Grave, 2017). However, there are also those who argue against the transdiagnostic model, and the central thesis that all eating disorders are variants of a single disorder with a common causality and maintaining factors (e.g. Birmingham, Touyz & Harbottle, 2008). For example, one large sample study examining transdiagnostic and diagnosis-specific maintaining factors found evidence of both (Lampard, Tasca, Balfour & Bissada, 2013), suggesting that a transdiagnostic model for eating disorders may be overly simplistic.

Burton and Abbott (2019) also suggest that a stand-alone model for understanding BED, drawing on key overlapping constructs and conceptualisations of binge eating, would be more useful. Their hypothesised model of binge eating focuses on five variables thought to maintain binge eating: the presence of negative affect/distress, poor emotional regulation, dietary restriction, eating beliefs and core low self-esteem. While their model has some overlap with the transdiagnostic model, it is specific to binge eating and seems to draw more comprehensively from the literature.

Alternatively, Treasure, Leslie, Chami and Fernández-Aranda (2018) have argued that the transdiagnostic model does not fit many individuals with eating disorders, in particular, those at either end of the weight spectrum, and have proposed a model which incorporates ideas drawn from the theoretical and empirical literature on food addiction to provide what the authors argue is a stronger explanation for recurrent bingeing behaviour (including that found in BED). This model includes a focus on eating behaviours and a consideration of aspects such as the salience of food reward.

While the transdiagnostic model has been criticised, it is still a dominant model in treatment (e.g. recommended in NICE guidelines for BED treatment, NICE, 2017). Treatment based on this model is termed CBT – E (cognitive behavioural therapy enhanced). CBT – E targets shared clinical features regardless of eating disorder diagnosis and is primarily focused on identifying and refuting dysfunctional thoughts and behaviour modification (Fairburn et

al. 2003). Further, the transdiagnostic model suggests treatment developed on this theory of commonality should be successful with all ranges of eating disorders.

Although there are limited studies looking at the application of this model specifically to BED, CBT- E has shown to be moderately effective with BN and binge eating behaviour with 30-50% individuals showing improvement (Treasure et al., 2018, Fairburn, et al., 2003). However, in a recent meta-analysis more evidence for the effectiveness of CBT -E is being called for (de Jong et al., 2016).

In sum, the transdiagnostic model has been an influential theory within the broad field of eating disorders and within BED treatment in general. Nonetheless, some researchers have argued that the model does not provide a sufficient explanation for BED, and there is a lack of strong evidence (to date at least) for the effectiveness of CBT-E for BED.

Psychodynamic Theory

Psychodynamic theory is of particular relevance for this thesis because it can be considered as providing a relational model of explanation, which focuses on the distal (historical) influences on binge eating. Another point of difference is that psychodynamic theory views the behaviour of binge eating and food itself as fulfilling an intrapsychic purpose (Burch & Siassi, 1973), and as a way of communicating or expressing underlying issues (Zerbe, 2001).

Generally speaking, psychodynamic theory holds the view that when needs are not met in human development, maladaptive functions occur as a consequence. These maladaptive functions serve as substitutes for developmental deficits and protect against the resulting pain, anger and frustration (Burch & Siassi, 1973). However, the maladaptive functions do not resolve the underlying deficits. An individual who never learned the ability to self-soothe, may use food as a means of comfort and may binge eat when upset, but in doing so will perpetuate a situation in which they do not learn to self-soothe (Burch & Siassi, 1973).

Psychodynamic theories posit that disordered eating emerges in response to particular relational deficits, particularly those related to caregivers in childhood (Sands, 1989, 1991, 2003). Psychodynamic theories of BED are therefore different from the other models presented thus far because they consider the role of distal influences and, in particular, problematic relationships with caregivers in early childhood. This is an important idea, but it has not been empirically tested, although see section below on familial predictors of BED.

Systemic Theories

Systemic theories posit that individual psychological phenomenon should be understood ‘systemically’, that is as necessarily arising from and best understood in terms of the social networks in which individuals live (both families and broader school, work and community networks) (Finlay, 2015). Family environment has been long suggested as a significant contributing factor for eating disorders including binge eating (Hernandez-Hons & Wooley, 2012; Hodges, Cochrane & Brewerton, 1998; Johnson & Flach, 1985; Minuchin, Rosman, Baker & Minuchin, 2009; Rommel et al., 2012). In the late 19th century Gull (Gull, 1874) suggested limited parental contact during treatment of AN was essential to prevent parental enabling of the eating disorder. The role of the family was further reframed in the late 1960’s in the work of Bruch (1962; 1973), Palazzoli (1974) and most notably Minuchin (1974). Minuchin et al. (1975) referred to the “psychosomatic family” in their influential model which placed emphasis on pathological familial processes in the development of AN – something the model has been criticised for (Downs and Blow, 2013). As a result of these theories, altering the family structure, through family therapy, was suggested as an effective way of treating AN. However, studies showing the effectiveness of the “psychosomatic family” model did not find any identifiable type of familial pattern linked to AN (Dare, LeGrange, Eisler & Rutherford, 1994); further, there was little supportive evidence for the idea that families ‘cause’ eating disorders (Eisler, 2005).

While the notion of family causation has been challenged, research has continued to examine familial factors associated with eating disorders. The first study to look specifically at the family characteristics of binge eaters was Hodges et al., (1998), who found that BED families were more conflictual, less cohesive, less honest with their feelings and more disorganised. Dominy, Johnson and Koch (2000) found that obese women with BED experienced parental rejection – especially paternal – and longed for more affection and nurturance in the child – parent relationship. Weight-related teasing and parental emotional unresponsiveness have also been found to be associated with binge eating in children under the age of 12 (Saltzman & Liechty, 2016). Such research suggests that family environment may be important contributory factors for the development of BED and suggests the value of family-based treatments and systemic approaches.

Current systemic/family treatments were pioneered at the Maudsley Hospital in London. These family-based approaches are built on an attitude of inclusion, with the family understood as a potential resource in therapy and with one aim of therapy being the easing of any parental guilt (Le Grange, Lock, Loeb & Nicholls, 2009). Within this approach, family systems theory focuses on helping the family to develop skills to better navigate differences of attitude and opinion, facilitate emotional literacy and communication and to recognize how rigidity of behaviour and emotionality at times may be sometimes associated with eating disorders (Dare, Eisler, Russell & Szumukler, 1990; Dodge, Hodes, Eisler & Dare, 1995). Family models of eating disorders also posit that family members are interconnected systemically, with each member having an impact on the whole, creating patterns of interaction which can be more or less helpful. This approach also acknowledges that these interactions, and meanings attached to them, may be experienced differently by each family member (Eisler, Simic, Blessitt & Dodge, 2016).

Despite the long history of systemic approaches to eating disorders, and the influence of family-based treatments in the area, the research on systemic approaches to eating disorders is still relatively limited and mostly based on

adolescent patients. The existing evidence suggests that family-based treatment and the Maudsley approach for treating for eating disorders is broadly effective, especially for early onset AN (Downs & Blow, 2013; see also Reinecke, 2017) although the evidence for BN is more mixed (Le Grange et al., 2007). There is however a lack of research on BED (Downs & Blow, 2013) with almost no research looking at the efficacy of family-based treatments for BED. For example, while Shomaker et al. (2017) examined a family-based intervention for at-risk preadolescents with disordered eating including binge eating (and found favourable results) this study was a small sample, pilot study focused on risk of excessive weight gain and it did not involve participants formally diagnosed with BED. Perhaps in reflection of the current state of the research, while family-based therapy is currently in the NICE Guidelines as the first line treatment for adolescent with AN and BN, the Guidelines make no provision for family-based treatments adolescents with BED (NICE, 2017).

Outside the sphere of treatment of children and adolescents, systemic understandings of BED have been suggested by one study focused on adult patients seen in an out-patient eating disorder unit in Denmark. Meyer, Waadegaard, Lau & Tjørnhøj-Thomsen (2019) used qualitative methods to examine outcomes of a multi-modal (including systemic) treatment for BED patients who were also overweight, in an effort to understand how to promote weight loss alongside reductions in BED symptomology. The authors' analysis led them to suggest that BED is usefully conceptualised as a relational problem in which feelings of non-acceptance due to weight are associated with having an identity which is dictated by one's body weight, and where there is a strong internalised sense of the critical gaze of others being focussed on one's body and weight (Meyer et al., 2019). The authors concluded that their study results suggest the benefits of a weight acceptance model for treatment of overweight individuals with BED but implicitly this study also suggests the value of systemic understandings also for adults with BED.

In summary, theory and research on eating disorders broadly suggest that families can play a role in the etiology and maintenance of eating disorders but only as one factor among others (Le Grange et al., 2009). While research on family-based and systemic approaches to BED is scarce, there are grounds for suggesting that this may also be the case for BED.

Feminist Theory

Feminist theory offers a sociocultural explanation of eating disorders (Brown & Jasper, 1993; Brumberg, 2000); 'fat studies' offer a related and overlapping understanding of the pressures experienced around weight and eating, in particular for individuals who might be defined as 'overweight' or 'obese' (Farrell, 2011; Rothblum & Solovay, 2009).

Feminist theory postulates that eating disorders are not an internal pathology but rather a 'pathology' of current cultural times in which few women do not have some obsession with their bodies or food (Brown, 1994). Feminist Theorists argue that preoccupation with weight and shape, and consequent disordered eating, does not just impact a small number of women as the DSM classification system suggests (APA, 1994) but rather that there is a normative discontent about shape and weight for the majority of women (Brumberg, 2000; Striegel-Moore, Silberstein & Rodin, 1986). It is also argued that the inclusion of eating disorders in the DSM validates the widespread beliefs about the importance of weight and shape for women, and frames women's experiences and bodies as pathological (Malson & Burns, 2009). Furthermore, that this conceptualisation of eating disorders as an individual medical problem discourages the exploration of socio-cultural influences on eating disorders and obscures the connection between the conditions of women's lives and their eating experiences. Thus, in contrast with the medical models of eating disorders, feminist theorists typically have a focus on the familial, social and political aspects of women's lives (Malson & Burns, 2009). The feminist explanation for eating disorders prioritises the role of societal pressures regarding weight and shape, a patriarchal society, unequal

distribution of power, media influences, being female and problems of identity and role conflict (Brumberg, 2000).

The research and theory that comes from the 'fat studies' perspective takes a critical stance on the notion of an 'obesity epidemic' and suggests that, for cultural reasons, weight is increasingly (but not accurately) understood as a straightforward proxy for both physical and mental health in a way that is pathologising to fat individuals, in particular women (Tischner, 2013).

Earlier, the impact of weight bias on how medical professionals perceive and work with obese individuals was discussed, along with the consequent impact that obese individuals may avoid seeking medical help for both physical and mental health issues (e.g. Puhl, & Heuer, 2009). Research also suggests a role for internalised weight bias for BED, such that it may predispose individuals to binge (Durso et al., 2012; Pearl, White & Grilo, 2014a). Thus, theory in this area also posits a sociocultural explanation for BED, positioning the disorder as a potential cultural artefact, with the binge eating that is the defining characteristic of BED positioned as pathological (rather than, as in Roman times, aspirational) due to the cultural emphasis placed on food control and appropriate weight.

For the current argument, the significance of both the feminist and fat studies critique of eating disorders is that it emphasises the failure of other models to consider the sociocultural factors involved. These factors are likely to be important given that, as discussed in the section on epidemiology, BED is (a) normative for some populations and (b) influenced by cultural factors.

Summary

This overview of theoretical models for binge eating suggests that models that seek to explain the individual psychological factors associated with development of BED are most common, with relatively less attention paid to relational and sociocultural explanations. This review suggests the value of explanations at various levels – biological/genetic, psychological, familial/relational and socio-cultural however no meta-model that considers

all explanatory levels yet exists. In addition, while the psychological models may be most developed no one model has conclusively stronger empirical support. Despite this, the role of negative affect as a trigger and difficulty with affect regulation as a vulnerability factor is suggested.

BED Risk Factors

The review of theoretical models suggests a lack of clear empirical support for any particular theoretical model. Another pathway to understanding binge eating is a study of factors associated with it; as opposed to the deductive approach with the theory driving the research, this is an inductive model for theory building. There are a number of risk factors that have been discussed in the literature, but there is little consensus over their significance (Pike et al., 2006). These risk factors include socio-cultural risk factors, in particular pressure to be thin, ideal body internalisation, body mass, body dissatisfaction, dietary restraint, familial factors and negative affect. These risk factors are presented next and the empirical evidence for them evaluated.

Socio-cultural

Pressure to be thin: A large body of literature focuses on how the cultural pressure to be thin impacts on the prevalence of eating disorders (e.g., Polivy & Herman, 1993).

Pressure to be thin has been identified as a pervasive risk factor associated with eating pathology by elevating body dissatisfaction in women (Stice, Shaw & Nemeroff, 1998; Stice, Presnell & Spangler, 2002; Striegel-Moore, 1993). According to Stice and colleagues (1998), pressure to be thin from family, peers, romantic partners and the media may lead to binge eating by increasing the likelihood of dieting. Overall, perceived pressure to be thin appears to be a predisposing factor that may ultimately lead to binge eating, something that is of concern given that this is a pressure experienced by many and is, arguably, socially embedded/accepted.

Ideal-body internalisation: Research has also posited that internalisation of an ‘ideal’ (e.g. thin) body is a key factor in the development of BED (Stice, Ziemba, Margolis & Flick, 1996; Stice et al., 2002). For example, experimental reduction of thin-ideal internalisation resulted in decreased body dissatisfaction, dieting, negative affect and binge eating symptoms (Stice, Mazotti, Weibel & Agras, 2000). Internalisation of a thin ideal thus appears to place individuals at risk for onset of binge eating and could lead to the development of BED.

Dieting: The socio-cultural risk factors outlined above are thought to increase dieting behaviours and dieting itself appears to predict binge eating, as discussed in the dietary restraint model previously.

Familial Factors: As discussed in the earlier section on systemic theory, family environment has been suggested as a significant contributing factor for eating disorders including binge eating (Hernandez-Hons & Wooley, 2012; Hodges, Cochrane & Brewerton, 1998; Johnson & Flach, 1985; Minuchin, Rosman, Baker & Minuchin, 2009; Rommel et al., 2012).

Negative emotions: Negative emotions, including depression, anxiety and stress are also risk factors for binge eating. (Anestis & Joiner, 2011; Striegel-Moore & Bulik, 2007). BED is also frequently associated with low self-esteem which Dunkley and Grilo (2007) conceptualise as a “*global negative view of the self*”(p. 140).

To summarise, the research on BED risk factors suggests BED is associated with (a) difficult family circumstances and (b) factors related to feelings about the body, as well as (c) a history of dieting. The former provides some evidence for the psychodynamic model of BED; the latter for the feminist model or socio-cultural causes of BED. However, the research findings in the area are still tentative.

Experiences of living with BED, Bulimia and Obesity

To this point, all of the evidence that has been considered for BED has been quantitative or located within a positivist paradigm. However, the review

of the critiques of BED as a diagnosis, as well as the evaluation of both the theoretical models and the risk factors empirically associated with BED suggest the following: (a) a positivist approach to BED may be limited in scope; (b) a medical model approach to BED does not seem to adequately explain BED; (c) an approach to BED that gives voice to the individual experience, and allows for a discussion of familial and socio-cultural aspects of BED may be important. In sum, a qualitative exploration of BED is called for.

However, there is a lack of qualitative research directly focused on BED, despite a growing qualitative literature focused on other eating disorders (e.g. Broussard, 2005) and on the experience of being obese (Thomas, Hyde, Karunaratne, Herbert & Komesaroff, 2008).

One of the few studies using qualitative methodology to look at BED was conducted by McIver, O'Halloran and McGartland (2009). Data from twenty personal journals were analysed, using existential phenomenological enquiry, to examine the experience of a twelve-week yoga programme for obese women who binge eat. However, the study is focused on the experience of treatment (here yoga) and not the experience of BED itself.

Most relevant for the current study, Krentz, Chew and Arthur (2005) conducted a qualitative study, using grounded theory, on the subjective experiences of women who had recovered from BED. The purpose of the study was to characterise the psychological processes of recovery from BED. Unstructured interviews were conducted with six women who had recovered from binge eating for a minimum of six months and met the DSM-IV criteria for BED. The authors concluded that a core theme or category of "*self-awakening*" must be present for recovery to occur. "*Self-awakening*" however, is made up of four emergent themes or phases: self-reflecting, assessing present life situation, healing/restoring oneself and creating balance. The participants in this study discussed the influence of external messages on weight and binge eating. In addition, the participants reported various forms of abuse and family problems which often served as the contexts in which binge eating began (Krentz et al., 2005). The findings in this study also point to the participants reporting poor body image, low self-esteem and depression.

Prior to recovery, their struggle to be thin was accompanied by negative thoughts about the body.

A more recent study on the same topic is that by Lord, Reiboldt, Gonitzke, Parker and Peterson (2018). The aim of the study was to investigate the changes in thinking of recovered BED sufferers, based on anonymous postings on a pro-recovery website, and to understand how certain factors, such as self-blame and guilt, affect recovery and also the motivators behind recovery and the challenges faced during the process. Narratives, relating to BED, of 65 participants were analysed with coding strategies to expose patterns within the experiences of the participants. Three key themes were highlighted: acknowledging the disorder, identifying unhealthy coping behaviours and visualising recovery. Further findings suggest that self-blame, guilt and weight loss attempts inhibit recovery by promoting a detrimental feedback cycle of bingeing and encouraging disordered eating. Conversely, validation was found to lead to recovery as participants were less likely to partake in disordered eating. Both Krentz et al., (2005) and Lord et al., (2018) provide important information about the experience of BED. However, the focus of both studies is on recovery rather than the experience of BED per se.

Another useful study is by Eli (2015) which focuses on how patients with BN and AN experience binge eating and how they interpret these experiences. Interviews of sixteen women were analysed using phenomenologically-informed thematic analysis. Participants described how binge eating creates a sense of release and results in an overwhelming sense of fullness replacing existential emptiness. It was concluded that these experiences of release and fullness contribute to the maintenance of binge eating. However, this study is not focused on individuals who meet criteria for BED, and, as argued, the experience of binge in BED is likely different from that in other eating disorders.

Carey, Saules and Carr (2017) conducted research investigating men's experiences of binge eating. The grounded theory approach was utilised to examine testimonials from eleven overweight/obese male college students. Findings suggest that gender biases exist in the current diagnostic criteria for

BED, with aspects of the disorder, such as overeating, consistent with male gender role and other aspects, such as loss of control, more consistent with the female gender role. The authors concluded that men and women experience related, but ultimately distinct, binge eating disorders because men are not subjected to the same social pressures as women around food and eating. This suggests the value of a study focused exclusively on women.

To date, there is very limited qualitative research focused on BED, only four studies, and one additional study focused on the experience of bingeing, but not for those who meet criteria for BED. Of the four studies on BED, one includes only men, although women are the majority of BED sufferers; one is focused on the efficacy of a yoga treatment rather than on experience of BED and the remaining two are focused on perceptions and experiences of recovery. To date no study has been conducted on how women who meet criteria for BED experience BED - thus providing a rationale for the proposed study.

Summary

This review has critically considered how BED is defined (diagnostic criteria) and presented information on epidemiology and comorbidity for BED. BED is not only the most common eating disorder, it is also associated with a range of serious physical and psychiatric health conditions, in particular for those who both meet criteria for BED and are obese. As such the relative lack of research on BED is of concern.

The literature review then considered various theoretical explanations for BED, arguing that to date no one theory provides a satisfactory explanation for BED although, as indicated also by the section on risk factors for BED, the evidence is promising for a number of contributory factors.

Lastly, the very limited qualitative research on how people who meet criteria for BED has been reviewed and an argument has been made for the value of a study which focuses on women and which explores their lived experience of BED.

Aims and Objectives of the current study

In view of the literature that has been reviewed, the core aim of this study is to add to the tiny qualitative literature on BED by looking at an area not previously examined – how women make sense of and experience binge eating disorder. In doing so, one objective of the current study is to use the accounts of the women to consider the extent to which various theoretical and empirical understandings of BED tally with how women who meet criteria for BED themselves experience and understand their ‘disorder’.

Broader objectives for the study are that it will contribute to the literature on BED, an eating disorder that has serious interpersonal and health implications and which requires more empirical research. Knowledge of the conditions and circumstances that contribute to BED can help create effective and meaningful treatments for women who binge eat and thus inform the practice of psychologists, counsellors, nurses, doctors and other practitioners working with this population.

Chapter 3: Method

The following section sets out the rationale for the selected method, approach to participant recruitment, data collection and analysis and how research quality was maintained. This section also contains a reflexive statement.

Qualitative Study Design

Given the limited knowledge about the experiences of women with BED, an exploratory qualitative method of investigation was chosen. In line with the aims of this research, qualitative methodology is particularly useful both for examining the experiences of individuals and for exploratory inquiry and research (Braun & Clarke, 2013; Wertz, 2005; Willig, 2012). Additionally, qualitative research methods allow participants to share experiences that are complex and nuanced, as previous researchers have noted (Boyatzis & Quinlan, 2008). Qualitative research methodology incorporates the use of the researcher as an instrument for data collection, which further allows for the emergence of feelings and thought processes that could not be obtained through quantitative data collection (Willig & Stainton-Rogers, 2008).

The research questions in this study call for an approach focusing on the individual's lived experience in order to uncover, describe and interpret the subjective personal meaning of the participants' experiences of binge eating (Willig & Stainton-Rogers, 2008). The qualitative research paradigm is appropriate for this research because it allows for focus on both the nature of a phenomenon and the nature of the social process surrounding that phenomenon (Bryman, 2001). Qualitative research is also particularly well suited to illustrating the quality of people's experiences, with topics of sensitivity and emotional depth in order to capture the lived experience from the perspective of those who are creating meaning from that lived experience (Strauss & Corbin, 1990). Most of the literature looking at eating disorders, and BED in particular, is epistemologically positivist in nature and is focused mainly on diagnosis and treatment. The positivist stance in such research

usually assumes a quantitative research design with the goal of understanding the 'truth' or 'reality' of the phenomenon, in this case BED. In the case of BED a positivist stance does not question the 'reality' of BED or consider the idea that BED is socially construed.

Qualitative methods are additionally appropriate because they are typically not as reliant upon the assumptions of the natural science tradition, for example, that an objective reality exists independent of the human observer and that this reality is capable of being measured by the methods of scientific research. Qualitative methods consequently allow for an alternative way of studying specifically human phenomena (Willig & Stainton-Rogers, 2008); and as such are highly appropriate for complex personal and social issues such as eating disorders (Dibsdall, Lambert & Frewer, 2002). A qualitative approach begins in a more questioning place, something that felt important in the current project given (as discussed in the literature review) the lingering debate about whether the diagnosis of BED is valid or 'true'.

This study focusses on the lived experience of women with BED. Given the over representation of women in certain diagnostic categories such as eating disorders (including BED) and depression, Cosgrove (2000) highlights the importance of using qualitative research as a way of "*generating meaningful information about women's experiences of emotional distress*" (p.247). She suggests that a move away from a positivist approach allows for women's experience of 'distress' to be better understood as a social as well as a personal event as this helps inform and influence the dominant medical model.

Qualitative methods are thought to be a good choice for psychological research (Smith, Flowers & Larkin, 2009). Further, qualitative methods are a good fit with counselling psychology because of shared values (e.g. a focus on the value of subjective understandings) and a shared assumption that knowledge is not gained by passive observation but actively constructed from exploration of an individual's internal world (Yeah & Inman, 2007). While qualitative methods have a strong and growing presence in counselling

psychology in the UK (British Psychological Society [BPS], 2005), this is not the fact in the USA where there is a call for more methodological diversity, especially in counselling psychology (Poulin, 2007). However, it can be argued that there is value to counselling psychology continuing to embrace methodological pluralism; collaboration between quantitative and qualitative researchers potentially facilitates more comprehensive theoretical models which ultimately improves the quality of services provided to clients (Ponterotto, 2005).

Epistemology: In the current study a critical realist position is taken. Various epistemological positions can be taken by the researcher in psychology including positivist (Lincoln & Guba, 2000; McLeod, 2003), objectivist (Crotty, 1998), and pragmatist (Creswell, Plano Clark, Gutmann & Hanson, 2003; Tashakkori, Teddlie & Teddlie, 1998; Tashakkori & Teddlie, 2003). Critical realism can be described as an intermediate position between positivism and social constructionism (Barker, Pistrang & Elliott, 2002; Braun & Clarke, 2013; Burr, 2003). The social constructionist position assumes that participants' understandings of their binge eating are developed through their own interpretation then understood within the context of their lived worlds (Willig, 2013). In contrast, critical realism postulates that realities exist outside of the mind (Crotty, 1998) and that reality exists independently from our experiences and perceptions, while assuming knowledge not to be objective (Finlay, 2006; Lyons & Coyle, 2007). A critical realist stance chimes with counselling psychology due to the fact counselling psychologists seek to understand and respect people's subjective accounts (BPS, 2005). The current study utilises IPA. Epistemologically, IPA typically takes a critical realist approach and aims to produce knowledge derived from individuals' cognitions/meaning making about the phenomenon being investigated (Braun & Clarke, 2013).

Various qualitative methods were considered for use in this project and this process is considered in the next section, however first the approach

chosen – IPA – is described as the characteristics of this approach explain the reasoning for choosing IPA.

Interpretative Phenomenological Analysis - IPA

Interpretative Phenomenological Analysis (IPA) is a qualitative research method purposely designed for use in psychology (Smith et al., 2009). Trying to understand the lived experience and how participants themselves make sense of their experiences is the main concern of IPA (Smith, 1996). IPA attempts to focus on the experience as it is perceived by the individual, rather than producing an objective statement. The method also tries to eschew theory about the phenomenon, facilitating inclusion of experiences of the participant and not being driven by preconceived expectations of the researcher (Shaw, 2001).

The three key theoretical underpinnings of IPA are phenomenology, hermeneutics and idiography (Smith et al., 2009; Smith, 2011). These perspectives are not exclusive to IPA, rather it is the way they have been combined and the specific emphasis and approaches to data analysis used within the method that makes IPA a distinct approach within the field of qualitative analysis and more specifically phenomenology.

Both a philosophy and group of research methods, phenomenology is concerned with understanding and exploring human experience (Leahey, 1994). Unearthing the meaning of an individual's experience, or lived experience, of a specific phenomenon, is one of the main aims of a phenomenological researcher (Willig, 2012). IPA is phenomenological in that it seeks an insider perspective on the lived experiences of individuals and interpretative in that it acknowledges the researcher's personal beliefs and holds the position that understanding calls for interpretation (Willig & Stainton-Rogers, 2008).

The interpretative orientation of IPA is influenced mainly by the work of hermeneutic theorist Heidegger. Heidegger combined his understanding of

phenomenology with the theories of hermeneutics, interpretation, thus seeing phenomenology as an interpretive activity with the main emphasis on how individuals are making sense of their experience (Smith et al., 2009). Smith et al. (2009) clearly describe the relationship between interpretation and phenomenology and the necessity of the combination: “*Without the phenomenology there would be nothing to interpret, without the hermeneutics, the phenomenon would not be seen*” (p.37). The process of the “*double hermeneutic*”, with the researcher also an individual making sense of the participants’ sense-making of a phenomenon, is also acknowledged in IPA (Eatough & Smith, 2008). The concept of the “*double hermeneutic*” also refers to the expectation in IPA that the research occupies, at the same time, both a critical/interpretative and an empathic, non-judgemental stance. Thus, IPA calls for the researcher to, from a stance of empathy, walk alongside the participant (walk in their shoes) whilst also holding a questioning stance, and standing apart from the participant to see things from a different perspective. Good IPA should incorporate both of these positions of empathy and interrogative questioning (Smith et al., 2009).

The fact that the researcher is not free from preconceptions, which are necessary to understand the participant’s world, is a strong assumption of IPA (Eatough & Smith, 2008). Given that it is not possible to ever completely understand the lived experience of the participant, IPA aims to achieve a type of understanding through engagement with and interpretation of the participant’s world. This analysis is therefore both phenomenological, demonstrating the individual’s world view and interpretative, relying on the researcher’s own positions and world view (Smith et al., 2009). While other phenomenological approaches call for the researcher to ‘bracket’ any preconceived assumptions, IPA acknowledges these as implicit and necessary to develop interpretation and understanding (Willig, 2012). Given this, the importance of reflexive awareness on the part of the researcher is stressed, with the aim that researchers should seek to identify and reflect upon their experiences, assumptions and conceptions (Smith et al., 2009).

Another distinctive characteristic of IPA is the approach to sample size. IPA utilises an idiographic mode of enquiry rather than the nomothetic, which is very typically seen in psychology, and as a result is dedicated to the detailed analysis and understanding of the particular rather than the analysis of populations or groups. This is one of the key features distinguishing IPA from other phenomenological methods and a facet of the approach which allows the researcher to commit to the thorough study of each case as unique and individual (Smith & Osborn, 2003). Professional doctorate studies using IPA have a recommended sample size of between 4 and 10 (Smith et al., 2009; Willig, 2012), although Smith et al., (2009) also suggest a smaller sample size may be preferable, and samples of 6-8 are commonly found in other studies using IPA. Smith et al., (2009) suggest a smaller sample helps the researcher maintain an idiographic stance while helping facilitate depth of understanding as opposed to breadth, which is key in IPA. Several researchers highlight the appreciation for the emphasis IPA places on smaller samples sizes, stating that the data produced is poignant, emotive and interesting (Wagstaff & Williams, 2014). In this study therefore, the decision was taken to recruit between 6-8 participants.

IPA's focus on the specific individual experience, rather than a broader exploration of concepts (Smith et al., 2009) explains why IPA was chosen for this study. Furthermore, IPA is also thought to be interrogative in its capacity to contribute to and question existing psychological research (Rizq & Target, 2008), which was important for this study. As such, IPA is the most suitable method of analysis for the present research as it allows the researcher to explore individual's beliefs and understanding of binge eating and to consider this in light of existing theory/research on BED. IPA was also a suitable choice for this study because of the fit with counselling psychology.

Phenomenological traditions heavily influence counselling psychology (McLeod, 2003), therefore it is a recommended data analysis method in counselling psychology (Finlay, 2011). Wertz (2005), who strongly advocates the use of phenomenological research methods, claims that the "*approach is*

especially suited for counselling psychologists whose work brings them close to the naturally occurring struggles and triumphs of the persons” (p.176).

Other qualitative methods considered for study

In coming to the decision to use IPA for this study other methods were considered including Grounded Theory (GT). GT is a qualitative research process in which theory emerges from the data collected about the phenomenon under study. Findings are grounded in specific contexts and theories are generated from the emerging data (Willig & Stainton-Rogers, 2008). IPA and, especially, the subjectivist version of GT (Glaser, 1992), are quite similar in that they: try to develop a cognitive map that represents an individual’s world view; have similar approaches in analysis to develop core categories and master themes that capture the process and essence of the phenomenon under investigation (Willig & Stainton-Rogers, 2008). There were, however, drawbacks to using GT for this project. Willig and Stainton-Rogers (2008) suggests that GT typically subscribes to a positivist epistemology and that it does not address questions of reflexivity adequately, which would be limiting to the researcher given the importance of reflection in counselling psychology. Another drawback of GT is its pre-occupation with uncovering social processes. This limits its pertinence to more phenomenological research questions, such as exploring the nature of experience, which are more relevant in psychology (especially counselling psychology). Additionally, unlike GT, IPA does not have the development of a model as its primary focus.

When this project was first conceived, the use of Thematic Analysis (TA) was also initially considered. TA is “*a method for identifying, analysing and reporting patterns (themes) within data*” (Braun & Clarke, 2006, p. 79). TA is flexible in that it can be applied across a range of epistemological and theoretical approaches and thus allows the researcher more creativity. Braun and Clarke (2006) however, stress that if TA is not applied carefully it will create little more than a description and have little interpretative value.

Furthermore, TA does not offer the focus on the lived experience that is one of the main characteristics of IPA (Braun & Clarke, 2006) and an aim of this project.

After careful consideration it was therefore felt IPA was the best choice for the research question as the location of IPA within the hermeneutic framework promotes interpretation of nuances across individuals which could be missed by TA or GT (Eatough & Smith, 2008). Whilst either TA or GT might have been adequate for the study, IPA expects the researcher to be open to and a facilitator of the client's lived experience, which feels very person-centred and compliments the researcher's counselling psychology identity and approach to clients. Additionally, the fact that IPA asks the researcher to try to disregard any theoretical assumptions and prior knowledge, to walk with the participant as they share their journey (Eatough & Smith, 2008; Smith et al., 2009) is both in line with the aims of the research project and appealing to the researcher.

Recruitment

The BED population (as reviewed in the literature review) is heterogeneous, including both those who may be classified as 'obese' and those who may be classified as 'normal weight'. At the time of participant recruitment BED was not (yet) a formal diagnosis and there was a question about how to recruit participants who met criteria for BED but might also represent the range of women with BED. One suggestion was to recruit participants through a medical setting which offered weight loss advice and services. A hospital in the South West of England was approached and the client liaison for the hospital (also a fully qualified psychiatric nurse) agreed to assist in the recruitment process for the study.

It is recognised that the recruitment strategy has created a particular sample; all the potential participants were concerned either about their binge eating behaviour or about their weight or both. All were considering or had engaged with weight loss surgery. The particularities of the sample however were balanced by the clinical support offered to potential participants which

included provision of an empathetic and supportive environment as well as a clinically robust resource in the event that participants or potential participants were distressed by their participation/potential participation in the study. In addition, potential participants were all contemplating change which suggested that they might be open to discussing binge eating; this was important given the evidence of shame and secrecy in BED. In addition, working with the participating hospital allowed for the researcher to receive some training on engaging with the population prior to the interview process and to use a room in the hospital to conduct the interviews. It is noted that even with this support, only 50% of those who expressed interest in the study were successfully recruited into it. Information leaflets (Appendix B) with details of the study and how to participate were given to potential participants by the client liaison and the participating hospital.

Inclusion/Exclusion Criteria

In line with the focus of the study, the inclusion criteria for the potential participants were:

- Female
- Over 18 years old
- Scored 18 or above on Binge Eating Scale
- No previous diagnosis of BN or AN
- Not pregnant currently or in the last 12 months

The focus on adult women has been justified already; the decision to use a BED screening tool is discussed below. It was decided to avoid anyone with a prior diagnosis of AN or BN due to the wish to focus on a more 'pure' BED since (as discussed in the literature review) there is a neglect of this group in the existing literature base on bingeing. The decision to avoid those who were currently or had recently been pregnant was taken on the advice of the participating hospital in order to avoid any potential harm arising from research participation to an unborn or young infant.

Potential participants contacted the researcher to schedule a phone interview. If, after the phone interview, the potential participants wanted to continue, an interview was arranged at the participating hospital in the South West of England with the researcher. Interest in the study was fair, with twelve potential participants contacting the researcher and six proceeding with interview. Four potential participants chose not to proceed with the project after discussing the project with the researcher. No specific reasons for not proceeding were given but as a precaution these participants were given information on counselling and other services available. In addition, a follow up call was made by the participating hospital liason to discuss any potential issues that might have arisen as a result of the conversation with the researcher. Of the other three potential participants, one became pregnant, and the other two moved out of the area before the interviews could be completed.

BED screening

This project focusses on BED and it was important to think carefully about how to assess BED. Given the critical stance of counselling psychology on diagnosis (Blair, 2010; Honos-Webb & Leitner, 2001) consideration was given as to whether to screen participants for meeting the DSM-IV criteria for BED. As discussed in the literature review, the diagnosis of 'binge-eating disorder' has been contested but for this project the desire was to produce research that would impact both those that are given the diagnosis and those who work with it, potentially both populations who are already necessarily working with the diagnosis. Thus, it was decided to use a BED screening instrument to ensure that the women formally met criteria for BED and to use this (over self-report for example) as a key method for determining eligibility for the study. The BED screening instrument used was the Binge Eating Scale (BES) (Gormally, Black, Daston & Rardin, 1982). The instrument was not designed to formally diagnose BED but to screen for binge eating in obese, treatment-seeking individuals, however, research suggests that the vast majority of individuals with and without BED will be correctly identified using

the BES (Grupski et al., 2013; Hood, Grupski, Hall, Ivan & Corsica, 2013). Moreover, Duarte, Pinto-Gouveia and Ferreira (2015) found that the BES is a valid screening tool to discriminate clinically significant binge eating among women in the general population, even in a sample with a wide age range and varying BMIs. They concluded the BES was able to identify 96.7% of clinically significant cases of binge eating, showing a sensitivity of 81.8% and a specificity of 97.8% and “*is a reliable useful measure in screening binge eating in women from the general population*” (Duarte et al., 2015, p.45).

The BES is a questionnaire comprised of 16 questions with 8 items relating to binge eating behaviours and 8 items relating to the feelings and cognitions related to a binge episode (Gormally et al., 1982). Point values are assigned to each item and the BES is scored by adding the point value assigned to each question. Scores ranging from 0-17 = no binge eating; 18-26 = moderate binge eating; and 27 and greater = severe binge eating (Gormally et al., 1982). The BES is part of the participating hospital’s standard protocol. It is administered by their client liaison while assessing for other potential comorbidities such as BN and AN.

Participant Sample

Opportunistic sampling was chosen for this study. Samples collected in this manner are thought to offer better insight and perspective into a particular experience (Smith et al., 2009).

IPA advocates using a fairly homogenous sample (Smith et al., 2009). However, IPA also takes in to consideration the potential problems in sample recruitment if exclusion/inclusion criteria is too restrictive (Eatough & Smith, 2008).

This study focuses on the experiences of women, so men were excluded from participating in the study. In addition, an adult population was sought. The study inclusion criteria restricted the sample to adult women who met a BED diagnosis; given that individuals with BED are usually between the ages of 25 – 60 (Brewerton, 1999) a wide age range was preferred.

Six participants were recruited to the study; this number was seen as appropriate as it allowed for a detailed and idiographic analysis while meeting recommendations for a professional doctorate (Smith et al., 2009). Interviews ranged in length from 60 minutes to 120 minutes.

BMI and/or weight was not screened for and this was deliberate and supported by the fact that weight is not a criterion for BED. Furthermore, the researcher did not mention weight unless it was brought up by the participant themselves. Again, this was a deliberate choice and reflected concerns around not evoking weight bias in the research interviews.

Although weight was not a criterion for inclusion in the study, general observations were made by the researcher as to the participant's size and these are shared to illustrate the heterogeneity of the participants.

Participant characteristics are described in the table below.

Table 1 – participate profile

Name	Age	Ethnicity	Observed body weight	BES score
Alice	55	White British	'bigger'	22
Betty	47	White British	'average'	24
Claire	27	White British	'bigger'	29
Donna	46	White British	'bigger'	25
Eve	38	White British	'average'	18
Fran	57	White British	'average'	23

Ethical Considerations

Ethical approval was obtained for the study from UWE. In addition, approval from the Medical Advisory Committee at the participating hospital

was also granted. As with all research in psychology, but especially when using human participants, ethics is an area of important consideration. Diligence was taken in adhering to the Universities' ethical policies and also following the British Psychological Society's strict guidelines for conducting research.

Informed Consent

Participants were provided with an information sheet (Appendix B) and an opportunity to meet and discuss the project further before proceeding if necessary. This was done to ensure that participants were clear that the purpose of the project was to understand their experiences of binge eating. Participants were reminded that participation was voluntary and informed about what the interview process involved and that they could stop the process at any time during the interview. They were also reminded of their right to withdraw from the study at any time and there was a sheet offering sources of support if requested. In addition, participants were told they could contact the client liaison of the participating hospital at any time for any reason. On agreement to take part, a consent form was signed (see Appendix C) by both the participant and the researcher.

Confidentiality

Participants were informed that strict measures to ensure confidentiality would be taken throughout the entire research process. They were made aware that any identifying information would be removed from the transcripts and write up and pseudonyms would be used. It was also discussed that these written documents would be discussed with the researcher's supervisory team.

Data Collection

Semi-structured interviews

Following the formal consent process, interviews were approximately 90 minutes long (range 60-120 minutes) (Smith et al., 2009). Given that they were audio recorded it is considered good practice for the researcher to

explain why the recording is being made and how it is going to be used (Willig & Stainton-Rogers, 2008) and this was done. The meetings took place at a hospital in the South West, UK.

Data collection took place in the form of semi-structured interviews. IPA advocates the use of semi-structured interviews since they allow for the researcher and participant to enter into a dialogue where questions can be modified in light of responses and a particular area of interest to be probed in more detail (Eatough & Smith, 2008). Furthermore, semi-structured interviews allow for the building of a research relationship, which can be crucial for individuals who may feel uncomfortable when discussing such a personal and sensitive subject as their bingeing behaviour (Miles & Gilbert, 2005).

Research Instrument

To gain a better understanding of the lived experiences of women with BED a flexible data collection instrument incorporating prompts was used (Appendix D). According to IPA, set questions or pre-determined lists of themes are not usually used, as the purpose of the research is to explore the interviewee's perceptions of what is important about the phenomenon in question rather than to look at what the researcher deems important (Willig, 2008). The questions were meant to be open and exploratory, allowing for participants' accounts of their lived experience, understandings and how they made sense of these within the particular context of their lives (Shinebourne, 2011).

Transcription

The interviews were transcribed by the researcher at her home address to ensure privacy and confidentiality of data at all times. The audio-tapes are stored in line with University policy and procedure, which means being kept securely for seven years following completion of the project. Any identifying data is stored separately. All identifiable information was removed from the transcripts to ensure anonymity (Smith et al., 2009).

In keeping with IPA guidelines, the interviews were transcribed verbatim (Smith et al., 2009). Margins were allowed for on both sides of the paper to allow ease for the IPA process in the manner suggested by Smith et al. (2009). Given that the first stage of the analytical process begins with the transcription it is important for the research to acknowledge that even during this initial stage they will have an impact on the data (Eatough & Smith, 2008).

Data Analysis

The approach to the analysis followed the guidance offered by Smith et al., (2009). In IPA the analysis involves an attempt to identify dominant themes or clusters of meanings in each individual transcript. This involves a progressive interpretative process whereby the researcher starts with an initial identification of concepts in the participant's story and gradually clusters these topics together through a process of repeated reading of the text. After the interviews were transcribed they were analysed in a systematic fashion following the detailed description of the process as suggested by Smith et al., (2009). In keeping with an idiographic approach, the researcher began by looking at one interview in detail. The initial transcript was read several times in an effort to become familiar with the content. Notations and initial comments were made with initial coding taking place. At this stage the transcript was uploaded into NVivo 9, a Computer Assisted Qualitative Data Analysis (CAQDAS). It was felt NVivo 9 had features that would assist the researcher in maintaining and filing data, making theme extraction and comparison more efficient (Zamawe, 2015). Nvivo was used for the initial line-by-line coding of data. NVivo however was not used in the development of final themes; instead paper-based printouts of NVivo initial codes and related data extracts were printed out and sorted/collated manually into sub-themes and themes in an extended and iterative process (initially for each transcript as described below) by the researcher until the final theme structure was arrived at.

In keeping with the idiographic nature of IPA, each transcript was coded independently for each participant by creating a thematic code list for

each participant in a separate folder. It was only when all six transcripts were coded that a common list of codes, and then cluster codes, was created which incorporated all participants. At this point the transcriptions were all sequentially re-read, to ensure that codes noted in one transcript were checked in all other transcripts. Through this iterative process of analysis, a series of cluster codes were developed which were strongly grounded in the data and which included a focus on both common themes as well as attention to dis-confirmatory examples.

Approach to validity and quality

It is important to assess the quality of qualitative research to determine how applicable and relevant the findings are (Braun & Clarke, 2013). With regard to the quality of the qualitative analysis used in the present study, consideration was given to Yardley's (2000; 2008) four broad principles: sensitivity to context, commitment and rigour, transparency and coherence and finally the importance of the topic being researched.

Sensitivity to context can be demonstrated by sensitivity to the material obtained from the participants (Smith et al., 2009). The current study attempted to do this by ensuring the participant's voice was heard and was not extinguished by the interpretation. The researcher tried to ensure this by systematically supporting arguments with relevant data (Smith et al., 2009) and by being reflexive throughout the process.

Criteria for establishing commitment to rigour was established by the researcher, showing clear engagement with topic, immersion in the data, solid data collection and developing methodological skills (Yardley, 2000). Frequent supervision occurred during the early stages of the research to provide a strong foundation to build from. In addition, the researcher attended two 2-day IPA workshops, as well as other qualitative methods forums, to assist in the process of developing an understanding of IPA. Yardley (2000) also states "*commitment and rigour might be demonstrated by the effective use of prolonged contemplative and empathic exploration of the topic.*"

The researcher feels the duration of the project enhanced both the commitment and rigour of the project (p.222).

Coherence was addressed by ensuring a clear link between the philosophical perspective, the method of investigation and the research question and analysis (Yardley, 2000).

Efforts to establish and maintain transparency for the duration of the project include establishing an audit trail to show how the project developed and to demonstrate how the research process unfolded. Supervision provided a forum for a type of independent review which, as suggested by Smith et al., (2009) contributes strongly to the validity of a qualitative study.

Relevance of the topic being researched is thought to be the decisive criterion when judging a piece of qualitative research (Yardley, 2000). It is argued that this study enhances the dialogue and potentially sheds light on the very significant topic of binge eating, and that, through consideration of participants' lived experience of BED, theoretical understandings of BED are enhanced. It is argued that the contribution to literature is in terms of both clinical models of BED and in terms of the impact of broader socio-cultural context on experience of BED. This latter is relevant as Yardley (2000) suggests relevant qualitative research can complement quantitative research by illuminating socio-cultural processes.

It has also been emphasised that researchers using IPA should be able to demonstrate that they have been true to the double hermeneutic nature of the analysis method (Shaw, 2001; Smith, 2011). The researcher of the present study has ensured that they are being true to the double hermeneutic nature of IPA by reflecting on their research practice throughout the process, documenting their thoughts in reflexive journals and providing comprehensive appendices detailing all aspects of the methodology while continuing to consider how "*criteria for validity will be flexibly applied*" (Smith et al., 2009, p. 184).

Additionally, Vicary, Young and Hicks (2017) argue quality and validity when conducting IPA can be achieved in three ways; reflexivity, reflection and

journaling. The next section focuses on detailing the approach to reflexivity taken in this thesis.

Reflexivity

Reflexivity is a key component of strong qualitative analysis. This section details both how I engaged with reflexivity and provides reflections on the thesis topic and approach.

A reflective process: A reflexive approach to the research process is now widely accepted in much qualitative research (Ortlipp, 2008). Rather than attempting to control researcher values through use of a positivist method or by bracketing assumptions, IPA acknowledges these as implicit and necessary to develop interpretation and understanding (Willig, 2012). Given this, the importance of reflexive awareness on the part of the researcher is stressed to consciously identify, acknowledge and reflect upon their experiences, assumptions and conceptions. In IPA, researcher reflexivity is thus seen as a crucial aspect of the research methods and should be undertaken throughout the duration of the project (Smith et al., 2009). Keeping self-reflective journals is a useful strategy that can facilitate reflexivity, whereby researchers use their journal to examine personal assumptions and clarify individual belief systems and subjectivities (Smith et al., 2009).

In the process of this research – which took place over 8 years – I duly kept a series of research journals in which I documented my shifting engagement with the research topic and the data and reflected on the connections that arose between my own history/context and the phenomenon I was studying. I also utilised the process of research supervision with my shifting team of research supervisors to reflect on the project, in particular the data and my unfolding analysis. In addition, I made conscious efforts to engage critically with the research area and topic, for example through ongoing engagement both formal (e.g. I attended an IPA Masterclass with Jonathan Smith at Bournemouth University in 2012) and informal (for example

by seeking out media outputs relevant to the topic of my thesis (movies, newspaper stories etc.).

Epistemological reflexivity: This project takes a critical realist epistemological stance; it seems important to share something of my personal – beyond project rationale – journey to this position. Prior to undertaking the professional doctorate in counselling psychology, I completed two master's degrees based in the positivist paradigm and never considered, or knew you could, conduct research in any other way. My first master's degree was completed in finance in 1993, a time when qualitative research in that subject was virtually unheard of. Following that, in 2006 I completed a master's degree in economic psychology. Even though this course was in the Department of Psychology and not economics, exposure to qualitative methods was limited as there was, and still seems to be, an extremely strong focus on quantitative methodology in the department where I studied since "*most psychological research involves quantitative analysis of numerical data*" (University of Exeter website, 2018).

It was not until I commenced studies in counselling psychology at The University of Massachusetts that I was exposed in earnest to qualitative research. The department encourages students to take a critical stance towards the dominant medical model as well as towards diagnosis and quantitative methods. We were encouraged to be reflective both in our practice and our research and I soon began to see the possibilities qualitative analysis offered, not just in counselling psychology but all disciplines, including finance (see Kacyzinski, Salmona & Smith, 2014, who are advocates of qualitative methods in finance).

I felt like I was experiencing a personal academic renaissance. For the first time, in an academic setting, I had permission to look at things in a different way. This worked for me since it has always been my nature to question and be critical and a strict positivist stance never sat well with me even when studying economics and finance. Human behaviour is very much present in economics and I could never understand how you could take

human behaviour and simply reduce it down to fit into an economic model. What about what people were thinking and experiencing?

Personal reflexivity: Adhering to the proposed qualitative methodology guidelines on reflexivity (Ortlipp, 2008) I will now give a brief biographical summary so that my professional experiences and any background biases might be highlighted from the onset of the research.

I am a 48 year old woman with many categories of privilege: white, middle-class, able bodied, educated, heterosexual, 'normal' weight. This list implies a position as an 'insider', firmly located within a privileged cultural context, yet in some ways I have long also lived in a more in-between space. Although, I am American by birth, I have lived over twenty years in the UK, attended university in both the USA and UK and lived and worked in Asia. Subsequently, I have completed a master's degree in Counselling psychology in the US. I have lived in varied places in both the US and in the UK and my varied work and educational history mean that I have interacted with people from a wide variety of cultural and social backgrounds. The point of this recounting is to say that I feel I have occupied an outsider position at multiple points in my life despite my position(s) of privilege – e.g. as a woman in the male world of London City finance, as an American married to an Irish man living in the UK, as a 'haole' (term used to note those not of Hawaiian descent in Hawaii, particularly white people) working therapeutically in Hawaii.

I feel my life experience has had a broad influence on my decision to engage in the current project, which concerns an 'outsider' population that is vulnerable to stigma for their eating behaviour and (for some participants) weight. The journey towards deciding on the topic for this thesis also was sparked by a long-standing personal concern around my own body and weight and an intellectual curiosity around the topic of diagnosis.

At that time, DSM-5 was due for publication soon and it was known that binge eating disorder was likely to be 'upgraded' to a stand-alone diagnostic category. My attention was caught since in my MSc in Counselling

Psychology I took a class in ‘abnormal psychology’ taught by Professor Lisa Cosgrove (Cosgrove, Krinsky, Vijayaraghavan, & Schneider 2006; Cosgrove & Krinsky, 2012; Cosgrove, Vannoy, Mintzes & Shaughnessy, 2016) through which I was encouraged to develop a critical stance towards diagnosis, which is unusual for US therapy programmes. Given my scepticism around diagnosis, and the practical absence of qualitative literature on the subject I began to think that a qualitative project on BED would be both interesting and of value for the field. It seemed important to me that if included in the DSM-5, BED would become a diagnostic label that could be applied to more people than both the diagnoses BN and AN combined. I also noted that in the existing literature there seemed to be nothing about how people who met the criteria themselves understood BED. Did they experience it as an illness or was it a coping mechanism? Or was it just a social artefact, a by-product of society’s obsession with consumption and ‘ideal’ bodies and weight?

Alongside these intellectual concerns I had a long-standing personal interest. While I have (in my own view) never met diagnostic criteria for ‘binge eating disorder’ or any other eating disorder, my relationship with food/eating and my own body and weight has been fraught. Most of my life I have been a ‘normal’ weight, albeit with many fluctuations. I spent my childhood and teenage years in California where external appearance including weight is highly valued.

In terms of my relationship with food, I have a long history of dieting or trying to restrict my food intake to lose weight. I would say that also that I have had periods of engaging in bingeing. During my early teens, I distinctly remember becoming aware of bingeing. Eating too much, whatever that may be, became an issue and something my friends and I would talk about with comments from peers judging themselves on the quantity and type of foods being eaten. It was also during this time when I remember being judged, not only by myself, but friends and family, and greater society around the types and quantities of foods I would eat. With it came a feeling I had done something wrong or bad and trying to avoid foods which might trigger binge

eating. During college there would have been times of bingeing followed by restraint with an overall awareness of what and how a woman ate mattered. Further, it was during this time when I began to realise not only how much the size of a woman mattered not only to myself but most poignantly to greater society in general.

My relationship with my weight/body shifted after I had, at the ages of 40 and 44, my two children. During the first pregnancy my weight changed significantly falling into the 'obese' category as defined by BMI. I distinctly remember that day and thinking 'well now you just might be 'obese' for the rest of your life.' It was if being that weight would change who I was. While I chose the topic for my thesis before my pregnancies, I collected the data and conducted the analysis for the study between pregnancies. I think having the experience of being 'heavier' during my pregnancies gave me a different and important (quasi or past 'insider') perspective and more empathy during the interviews and subsequent data analysis.

I have been very struck by how people responded when I lost the 'baby weight' (more than 20 kilos) after each pregnancy and I think this experience too has been important for the thesis. The weight loss frequently evoked comment. People who did not know me prior to the pregnancies would express almost joy that I was thinner. People who did know me previously, including family, seemed relieved and would ask if I 'felt better' having lost the weight. Two years later, and currently, I weigh approximately 72 kilos – 'normal' but still wanting to 'just lose ten pounds'. Even at 48 I still feel something might be different (better) if I was just ten pounds lighter; this belief persists despite the fact that, as a result of my engagement with this research, I am now much more consciously challenging such thoughts.

A key influential concept in this process has been that of weight stigma. Through the process of this thesis I began to read up on weight stigma but it was not until I was conducting my analysis for what must have been the third time, that it became clear to me how significant 'fat shaming', from both family and greater society, was for these women. Moreover I came to realise

not only have I felt shamed for my weight myself but I have also perpetuated weight bias in my attitudes to others, but also to myself. Reflecting back, this is probably due to the messages I have received from society as well as familial experiences. I was taught that as a woman, a slimmer physique equates to more worth. Given my experiences of working in male-dominated work setting (finance and construction), the research on fat bias towards women in the work place also really resonated with me, including the findings that women are punished more for their weight. I have always known weight mattered, but exploring this research opened my eyes to the extent of its importance, especially for a woman.

Engaging in this thesis has thus prompted me to engage in serious reflection on the ways that I myself think about female bodies, weight and food and what the impact of my attitudes to these topics have been for me personally. I have also found myself increasingly challenging other people on their views, talking to the people around me about stigma and biases of fat shaming, especially for women. In doing so I have found that while many will acknowledge their own prejudices and biases, some will feel that these are justified because (according to the myth that weight is entirely within individual control) overweight individuals are responsible for their weight and thus to blame for not addressing it. Conversational experience of how hard it is to effectively challenge ideas around body weight has in turn further encouraged my belief in the importance of research which potentially challenges social prejudices about body weight for women as well as questions the value of labels such as BED.

Chapter 4: Results

This section presents the two emergent themes identified through the process of analysis; these themes and sub-themes are depicted in Figure 1. The first emergent theme focuses on what the participants think about why they binge, seeking to identify what their interviews suggest about the proximal triggers and distal causes. The second emergent theme focuses on what the participants think about why they continue to binge, thus the factors that maintain or perpetuate the bingeing behaviour. Themes are presented by describing each participant in turn; this was done to maintain the idiographic focus of the analysis and to enable the reader to understand how the participants' stories fit together. As such the sub-themes are identified within each narrative account for each participant. Further, it should be noted the participants spoke in a natural, chronological manner about their experiences of BED rather than the researcher organising the data in this way.

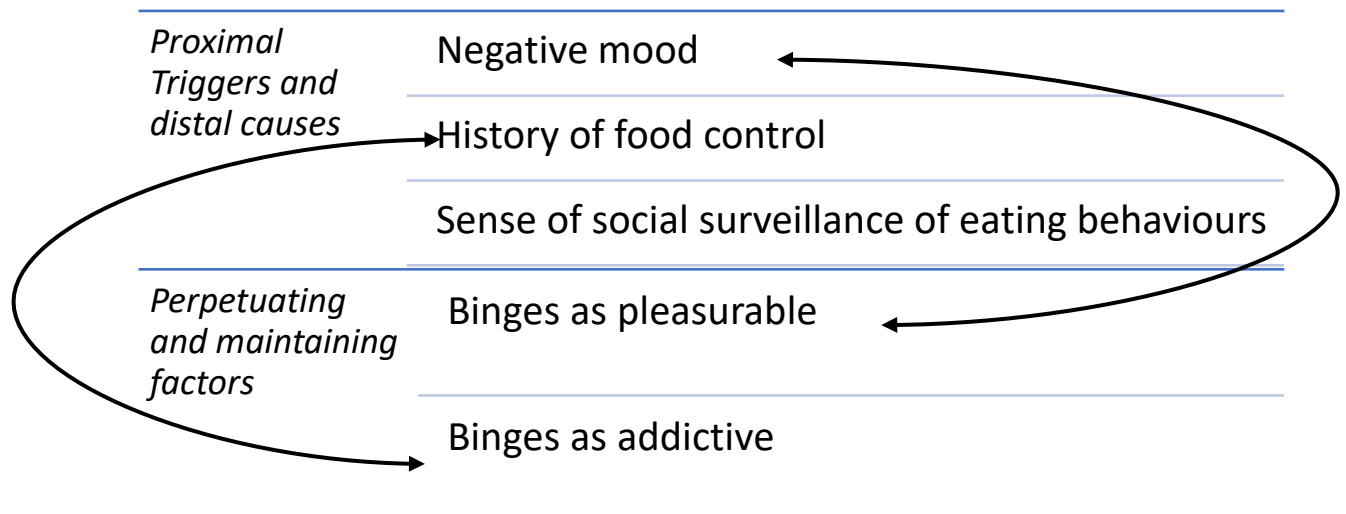


Figure 1. Depiction of the emergent themes and sub-themes showing relationships between sub-themes

Theme One: Proximal triggers and distal causes

The following reports on what the data reveals about the proximal triggers and distal causes for binges. Participants' statements are examined to assess what they believe might trigger them to binge and their understanding about why they binge. The analysis considers all statements which seem to focus on causes, even if the participants themselves did not directly make the link that what they are discussing functions as a 'trigger'.

Each participant is considered in turn with the analysis focusing on how they each make sense of their bingeing behaviour in terms of three sub-themes that were identified across the data corpus. These sub-themes were: (1) negative mood as a (current) proximal trigger; (2) history of food control in childhood as a distal cause, and (3) the sense of social surveillance around food and eating for the all-female participants as a contextual cause. As such, the analysis considers three potential explanations for bingeing: (1) psychological/individual, (2) relational and (3) social, as well as current and historical influences.

Also, emerging from the analysis for Theme One is in general, participants appear to have contradictory and limited understandings of their motives for bingeing.

Alice - Alice, discussed negative mood as a trigger for her bingeing: “*When I’m depressed I eat, and after... after one chocolate bar I feel happier and relieved.*”

She also associated bingeing with stress:

Normally when I’m feeling happy and not stressed and good in myself I don’t tend to eat, but it’s when you have had a stressful day at work or something bad has happened, (medium pause) or probably the fear of loneliness as well because that’s why when you’re on your own you... well I do tend to eat more as well because you’re like, ‘I’ve got nothing to do. There’s no-one to talk to. Let’s just eat.

In this quote Alice is aware bingeing is a by-product of feeling stressed. She also identifies two other potential negative triggers, loneliness and boredom. She appears to discuss stress in relation to work but she also mentions family is as a source of stress: *“probably family situations as well, you know? If there’s something stressful going on at home.”* It appears that in response to negative affect Alice frames bingeing as a coping strategy: *“There’s been a few like points in my life where I have thought, Oh God, I could just do with a chocolate bar right now.”*

Alice also discusses contextual opportunities that can act to trigger a binge. One factor is being alone: When asked if bingeing is something Alice only does alone she responded, *“Oh God, yes”* Alice also identifies the ability to buy her own food, something she was not able to do as a child: *“when I was living at home I couldn’t [binge]. I didn’t have the money to do it, but once you’re sort of live on your own and buy your own shopping...”*. Thus pondering why she binges, she says: *“I think it was having the freedom to do my own shopping and... Yes, I think that’s probably what it was.”*

Consequently Alice describes the escalation in her bingeing behaviour that came with more *“freedom”* saying that while she began bingeing in secondary school, *“eating more than I should”* and having *“the odd chocolate bar hidden away,”* it was only when she left home and had a new level of freedom and opportunity that this behaviour escalated, and she started to actively plan binges, buying food stocks for evenings when she knew her housemates would all be out.

Alice does not attribute her bingeing to the food environment she grew up in but, on questioning, does describe a home environment of food restriction:

There was always food in the house but there was just never what I call treats. Like there was never chocolate bars, there was never buns. There was none of the stuff you really crave.

Alice goes on to say that she was unable to eat the foods she was “*craving*” because she did not have her own money and when she bought food on behalf of her parents, receipts were scrutinised by her Dad. It thus appears that this opportunity trigger for Alice is related to the control around food which she experienced growing up.

Talking about her family, Alice seems to focus on her weight in comparison with other family members: “*I’m the biggest out of all the kids; even out of all the cousins I’m the biggest; I did use to be a fat kid*”. She describes experiencing negative comments about both her weight and eating from her family and extended family for most of her life, in particular her father, however he recently praised her for a ten pound weight loss:

He never gives praise ever. So... and for him to say that and notice it without anyone saying anything to him was quite... it made me quite sad... happy. And I thought, ‘Oh Bless him.’

The quote, with its unfinished sentence (“*was quite...*”) and the use of contradictory emotion adjectives, the incongruity of which Alice seemingly does not recognise, could suggest the complex emotions she feels towards the way her weight and body are evaluated by her family. There is a sense that Alice accepts at some level that her family are right to criticise her for being heavier and that the appropriate emotion when her father praises her for weight loss is happiness even if she actually feels quite sad.

Alice’s narrative suggests that she grew up in a home environment in which she experienced social surveillance around her eating behaviour, something that appears to have continued into adulthood. She goes on to describe secretive and deceitful behaviour when buying food, pretending it is for someone else: “*If it’s someone I know especially I’d say that [‘It’s for the kids’], so they don’t, once again, judge me.*” She also talks about how she monitors her food choices in social eating contexts:

I try and eat a bit healthier if I go out. I don't try and go for the rich things (...) If it's my true friends, close friends, they're not going to judge me on what I eat so I eat whatever I want, but if it's with people I'm not quite too keen on or don't know that well, I do try and stick to the healthier options that don't sort of judge me.

The notion, implicit in the quote above, that Alice is judged by the food (rather than her friends/acquaintances/strangers) hints at the sense of social surveillance she experiences when eating in public and points to the “freedom” that she may experience when bingeing alone. The secretive nature of Alice’s bingeing thus potentially is understood in the context of the social monitoring she feels her eating behaviour is subject to. This, indirectly, triggers her bingeing because she utilises situations in which she is not subject to social monitoring to binge freely.

This analysis suggests that a number of factors contribute to Alice’s bingeing behaviour. She portrays bingeing as a coping mechanism to deal with negative affect and as something that is triggered by opportunity factors, such as being alone and free to buy and eat the food she enjoys. She does not explicitly link her bingeing to the food control she experienced as a child, but the analysis suggests that this history may, in part, explain her bingeing behaviour. Similarly, she does not directly link the social monitoring of her body and eating behaviours to her bingeing but the analysis does suggest they may be linked. Overall the sense is that Alice does not have a coherent or developed awareness of the motives behind her binges.

Betty - When asked what triggered her bingeing behaviour, Betty denied that negative mood was responsible: “No! The depression is because of the eating. Most definitely. Because when I don't eat, over eat, my mind is absolutely fine”, suggesting that low mood is a consequence of bingeing, not a trigger. The blame she places on bingeing for causing her difficulties was a repeating theme in Betty’s narrative, perhaps due to the fact that at the time of interview

she had stopped bingeing regularly. However, contrary to this, she later in the interview implicates low mood as a binge trigger: *“You might cry because those jeans are tight in the morning, but you'll go out and eat a bar of chocolate to console yourself to the fact that they don't fit very well today.”*

Betty also describes how the recent loss of a job she enjoyed has triggered bingeing:

I'm sat on the sofa, watching whatever crap. And I haven't done that for years. I have not put daytime telly on for years and sat there eating and I have got into that little trap again, there's nothing to do, let's go down the shop a minute, get a few bars of this, a couple of packets of this and we'll watch whatever rubbish is on in the afternoon.

Betty does not directly state that low mood, stress, and boredom are triggers but it is implied. Betty also discusses feelings of shame associated with her bingeing:

..... you don't want to actually, you don't want anyone else to know that you are going to go and stuff all that so you do feel bad and you feel (short pause) - I think even as an adult anything you haven't got control of like that, you think, and other people have, you feel in superior don't you, you feel sort of, 'Oh why can't I be like that?' (short pause) You feel ashamed.

There is an interesting unfinished sentence at the first short pause where shame is implied as well as a number of repetitions and self-interruptions and the misuse of the word *“in superior”* instead of *“inferior”*. Together these discrepancies may suggest an emotional incoherence around Betty's reasoning for her bingeing.

Later in the interview, Betty refers to shame again in a somewhat more coherent way, and acknowledges her historical denial of the shame she feels about her bingeing behaviour:

I think that you do hide things because you are ashamed at the end of the day, you know, why can you control it and I can't, you know, and things like that and it is, you are ashamed and I think it's hard to admit this. I think as I have got older, if you had showed me this ten years, twenty years ago, I'd have gone 'No, I don't do that, no, I don't do that.'

The quotes suggest that Betty has now accepted the importance of shame in her experience of bingeing; they also suggest that potentially this difficult negative emotion has also been a trigger for her bingeing behaviour.

Like Alice, Betty engages in bingeing alone, “*all in secret obviously*”. Betty also alludes to the secrecy around her bingeing behaviour, and how “*I hide a lot of my chocolate consumption from everyone*”. She also discusses how she plans her binges and there is a sense, as with Alice, that opportunity is itself a binge trigger:

You hate yourself for it but, and you promise yourself you'll be good tomorrow until you drive past a garage, go past a shop or something like that or remember that there is something in the back of the cupboards at home and that's when it starts again.

Here Betty names both the opportunity to buy and the availability of binge-appropriate food as potential triggers.

Echoing Alice, Betty also talks about a history of food control. For example, she mentions how “*at school there was a dinner lady who absolutely would not let me leave that table until I ate every bit of vegetable and ever since I left that school I have never ate a vegetable.*” She also talks about negative childhood memories of sitting down for Sunday lunch:

We had a tiny, tiny kitchen, and I always had to have the seat rammed into the window, sort of really cramped. I hated the scenario of that, it would be the only day when Mum would cook, but that was the day when it had to be dead on so and so, everyone had to be and I hate that sort of life anyhow, you've got to do this, at that time.

The unfinished thoughts (“*everyone had to be...*”) and repetitive use of negative words like “*rammed*” and “*tiny*” reinforce the idea that Betty felt suffocated at these meals. Elsewhere in the interview she explains that she was only a teenager when she started getting “*too busy*” to eat sit-down meals with her family and that, even now, she tends to graze instead of eating full meals. Betty gives the impression that the oppressive nature of her upbringing has manifested into avoidance behaviour in adulthood.

Betty also explains how, from a young age, she internalised the belief that food intake needs to be controlled: “*when I was a teenager, say 13, I thought I was big, and I spent my school years on constant little diets, and I remember like me and my mum cut out little pieces of card with how many calories things were.*” Despite this she realises, when seeing pictures of herself, that she was not actually different in size from her peers at that age “*but up here, in my head, I thought I was big, I really did think I was big, and I wasn’t.*” This unfounded belief could be linked to her experience of food control as a child, which, in part, may explain her bingeing.

Betty has a long adult history of dieting and throughout the interview she displays her belief that being fat is unacceptable for her, remarking that: “*I would rather be dead than big in all honesty,*” a belief that is potentially influenced by her awareness of negative stereotypes about fat (weight bias). Betty talks vividly about her experiences of negative social surveillance of her body: “*I think people look at you different. I think there is a big thing of a big, fat, lazy, person, which I don’t think I have been and never have.*” Betty’s awareness of negative stereotypes surrounding fat people historically translated into a sense of anxious awareness when out in public which she herself terms “*paranoia*”:

I used to walk round when I was bigger and think everyone was staring at me, absolutely paranoid at everyone. I would be looking at shop windows

to catch my reflection but not seeing me, to see if anybody was looking at me, you know.

Betty also voiced her concerns that, had her weight continued to increase, she would have become a “shut-in”: *“I don’t need to see anyone because it is horrible.”*

For Betty the feeling of social surveillance is particularly present when eating:

When you are eating in front of people you do think they are thinking, ‘How much is she having?’ And you might be having a normal amount but you are sort of, up here, I think your brain is telling you, ‘I’d better not eat all this because they will think I’m greedy’. Even though they have ate exactly the same as you, but they’re slim.

Here she suggests that despite eating “normally”, she believes her portion size is judged as excessive and herself as “greedy” if she is fat.

In summary, while Betty explicitly rejects the notion that low mood, stress and loneliness trigger a binge for her, her account implicates these factors along with shame. Furthermore, opportunity can also trigger a binge, which is perhaps related to her childhood history of food control, both imposed by family members and internalised in terms of dieting behaviour. Betty’s account also suggests the presence of an awareness of negative social surveillance both of her body and of her eating. Overall it seems that the only time Betty can eat free from social judgement is when she binges alone, which may explain why she has faced difficulty in stopping.

Claire - Claire initially denies that negative emotions act as proximal triggers for bingeing: *“I...I don’t think there’s an emotional trigger with binge eating ...[it] isn’t linked to an emotion I felt that day.”* Instead she reasons that her binges are triggered by: *“emotions which I’ve had for a long time, such as a*

feeling of emptiness or loneliness,” describing these emotions as “much deeper”. However later in the interview she says: “Umm (pause) I’ve often tried to work this out. There has to be some form of trigger. And I’m not entirely – to this day, I’m not entirely sure what it is. It is to a large extent mood-based.” She also discusses a myriad of negative emotions as triggers, including boredom, loneliness and “feeling low”: “If I’m feeling unhappy or lonely or depressed or whatever, I will – I will physically go and seek out that binge.”

Claire also mentions physical triggers, such as hunger and tiredness, and how a sense of emptiness “*both physical and emotional*” will trigger her to binge:

I suppose with my eating that’s what I’m looking for, a feeling of fullness. Because I feel empty quite a lot of the time umm (short pause).

Here Claire refers to a current and pervasive sense of emptiness, however she also links her bingeing to historical emptiness:

I have felt in the past like there has been something missing inside. Like I feel like there’s some kind of hole. Or some kind of like – something missing. Like I’m trying to fill it up. So I’d forgotten to mention that before. But I suppose that is the reason why it all started. I just – I just purely felt hungry all the time at first. But then, as I got older, it was trying to fill up something that – that was missing.

Claire, who is one of only two participants who has had some psychological treatment for BED, later says that that her “*sense of emptiness that I can’t quite satisfy*” has been:

going on for...for a very, very long time. This...this feeling of (short pause) umm emptiness and... and despair I think at the fact that I haven’t, haven’t achieved what I want to achieve.

The pauses, repetitions and hesitancy (*umm*) suggest a tentative understanding that her bingeing may be linked to a sadness and sense of

failure rooted deep in her past. This understanding is distinct from the way the other participants describe the emotional triggers for their bingeing, in that Claire describes more than the everyday/surface emotions. However, she seems to have a limited understanding of why she feels empty, linking it predominantly to childhood (physical) hunger.

Thus, in Claire's account, one of the main reasons for her bingeing is a history of food control, in particular a history of feeling unsatiated as a child and never feeling "full". She recounts sneaking food behind her mother's back from the age of 5 and describes hunger as "*this horrible sort of feeling inside*", something that, as a child, felt like "*torture*": "*As a child I was always hungry, always, always hungry.*" This developed into a fear of hunger, which she attributes as one of the main triggers for her bingeing:

It's a fear of being hungry. I don't like the feeling of being hungry at all. So that – that's how it started in the very beginning. But now, it's less – it's more to just to do with habitualness. So it went from feeling incredibly hungry, and not liking that feeling, through to filling up some kind of emotional hole. And now it's just habitual. So it's kind of grown.

In this statement, Claire describes how her triggers have evolved, from physical, to emotional, to habit. There is a potential question of whether her hunger as a child was purely physical, however Claire does not seem to consider this possibility. Claire states that she always felt hungry, despite being fed "*the same amount as everyone*". She elaborates on the control exerted by her mother, explaining how she would tell her that she had eaten enough and "*more than you should have done anyway.*" Claire also reminisces about the fact that before she was "*fat*", "*I was always led to believe I was. Or I thought I was bigger than other people,*" illustrating the social monitoring her body was subjected to.

Claire says her history of her hunger needs being ignored or criticised is why she binges today: "*I think that's the main reason is because, is because*

[now] I have control over it and I can do what I want when I want to, rather than being told that I've had enough." Claire's narrative also suggests that opportunity is a trigger meaning she binges when she has time and money: *"And whether I have to do anything that day. Or whether I have money."* As she says: *"If I have enough money to buy, to buy food, then I will."*

Like other participants, Clare talks about experiencing a long-term sense of social surveillance of her eating, feeling like "overeating" was something, *"I shouldn't be doing it in front of people,"* even changing her behaviour when in social settings: *"I won't eat very much at those times. I'll eat like a normal person's portion."* The use of the word "normal" highlights Claire's endeavours to avoid negative social judgement by eating "normally". Similarly, she talks about how, *"I will specifically choose perhaps the healthiest thing on the menu, if I'm going out with my family,"* saying she does this because she worries *"about what they're going to think of me about what I'm eating"* and that *"I feel particularly with my mother that's she's watching me."* The sense of a feared judgement from her mother is clear but Claire also experiences judgement from strangers:

- *When you're having a meal with someone and you've...you've taken another portion of something and (short pause) and you know you shouldn't of done. And people are looking at you and... Or...or what they're thinking I don't know*
- *It makes you feel like you're being judged and watched because I'm the size I am you can't (pause)... Other people aren't exactly going to say 'Oh yes she really needs that other portion of cheesecake or...or she needs another sausage or...'*
- *If...if people are looking at me a normal portion of food would probably look like I'm overeating because I'm too big to eat normally.*

In the first quote Claire talks about being judged negatively by others but says she does not know what they might be thinking. However, in the second quote it is clear that she assumes because she is "the size I am" others

will be thinking she should not be eating “more” food. The third quote suggests that because she is the size she is, she cannot even eat “normally” without judgement. As she says: “*I don’t think I can ever eat normally because I feel like everyone else is looking at me and judging. So it’s not (short pause) there’s no way of eating normally.*” Poignantly, it seems due to the negative social surveillance she experiences when eating in front of others, it means the only place she can actually eat “normally” is when she binges alone, as it is only in those moments that she eats freely without judgement.

Claire’s experience of social surveillance of her eating as a fat woman is linked to a broader awareness of weight bias. She talks about her belief that “*big fat people*” are “*at the bottom of everything. The butt of all the jokes.*” However she also appears to have mostly uncritically internalised this bias. For example, she talks about how her binges have “*ruined*” her body, and that she feels she/her body are “*completely abnormal*” and that as a result she feels that she is not “*entitled*” to have children or family, that she is “*unlikely to...to be attractive to someone of the opposite sex.*”

Overall Claire’s understanding seems to be that both proximal and “*deeper*” negative emotions – especially a sense of painful emptiness – are triggers for her bingeing behaviour. She describes opportunities to binge as a potential trigger today and links this to her history of control around food in childhood, in particular her experience of not being allowed to eat enough to satisfy her hunger. She also experiences a current and strong sense of social surveillance of her eating in public spaces, as well as an internalised weight stigma, that means that binges paradoxically may offer her the only space in which she feels free to eat more “*normally*”. However, Claire herself does not make a link between her bingeing and her experience of weight stigma.

Donna: Donna clearly states that her binges are triggered by negative emotion, stress and boredom, “*it’s when you’re on a negative frame of mind that you binge*”:

- *I've been tri- what I would call triggered into doing it by being upset, stressed (pause) and bored.*
- *It's almost like you're feeling sorry for yourself (pause) type feeling*
- *I'm having a binge because I've lost it and I'm upset*
- *It's always when you're on a downer, you know when you're feeling something bad's happened or...*

Donna also cites settings in which she feels helpless, when “you can't control what's happening around you”; “I've been forced into sort of situations beyond my control that I can do nothing about and I turn to the cupboard.”

Donna additionally talks about anger as a potential trigger, as well as something being unfair. For example she cites a binge that followed an unsuccessful diet weigh-in: “I felt as though it was unfair so I went home [and binged.]”

Unlike some other participants, Donna does not appear to be triggered by opportunity. However, like the others she will not binge if someone is “watching me” and therefore does it in secret: “I'd wait for somebody to go off out the room and then I'd quickly open the cupboard and take another cake out the box.” Furthermore, Donna does not make any link between bingeing and a childhood history of food control, making little mention of her family, potentially failing to make a connection between family history and her bingeing.

At the time of interview Donna is on a long-term diet, has lost a substantial amount of weight and is mostly managing to avoid bingeing. Perhaps for this reason, Donna's narrative is different because she does not report the same sense of social surveillance around her eating. For example, she says:

This [national holiday] I'm going around mum's for meal. It's a family occasion. I'm not going to say I'm going to totally bloat out like I might have done before but yes, I probably am going to overeat a little, but that's okay because that would be once... twice a year, and because I

know I'm going to do that I will be actually good before and after, which sort of makes it okay.

In this quote, she appears in control of her eating, recognising that she will likely “overeat” but justifying it as acceptable because it is a social occasion which is balanced by disciplined eating before/after. However elsewhere in the interview Donna goes further and says:

- *Overeating is almost like a positive overeating umm because you're doing it with people. Umm which makes it sort of acceptable.*
- *While as if we went out for a meal, even though I know that I might be stuffed and I'm overeating that's okay because so's everybody else sat round you.*

Donna adds that social overeating is enjoyable both in terms of the food and because “*it normally goes with a good time as well.*” What is missing from Donna’s account is any sense that she feels that her eating has in the past been monitored by others because she was overweight and that as a result she has felt pressured or uncomfortable to eat as she would like to.

Contrary to previous comments, there are some suggestions in the narrative that Donna has felt social judgement, in particular about buying chocolate and about being a fat woman. For example, Donna divulges that historically she has “*used*” her children “*like a decoy*”, taking them with her to buy chocolate because she wanted chocolate herself, suggesting that she has in the past sought to avoid social judgement about her food choices. She also says, “*I feel good about myself at the moment. I'm not the big fat person walking up the street and I don't...I don't know.*” The “*I don't know*” is interesting here because there is a sense that she is alluding to no longer experiencing social judgement from others.

More broadly there is a sense that Donna has internalised a strong sense of weight stigma. She talks about how she recently admitted to someone about having a binge and that they were “*quite angry that I'd done it.*” She felt

this was an appropriate response because bingeing is “bad” and leads to weight gain. As Donna says: *“I don’t want to be fat;”, “And I don’t want to be that [fat] again;”, “I don’t want to put this weight back on.”* She also talks about how binge eaters are “big fatty people” and says: *“I don’t judge people but I will look at fat people and I’m like, Woah! They’re big and they’re fat.”* These contradicting quotes deftly illustrate Donna’s lack of awareness of her judgement towards fat people, and by implication her own historical fat self. Donna may be uncritically internalising weight bias but she also never attributes her awareness of weight stigma as explaining her history of bingeing. She also considers whether bingeing is a sign that she is “not right in the head”.

Overall, Donna’s narrative seems to suggest an understanding of her bingeing as being partly explained by feeling bad/low – a coping mechanism when upset - but otherwise as being inexplicable. She consequently places great judgement on herself for continuing to do something that she likens to self-harm: *“I don’t know why I want to hurt myself but yes it is almost like you’re hurting yourself (pause), inflicting myself with food – why? I don’t know, it’s strange.”*

Eve-Eve describes herself as having a long-term pattern in which her weight “yo-yos up and down hugely,” with periods of food restraint in which *“I can go days without eating”* and lose weight, and periods of bingeing in which she rapidly gains weight. In this context, Eve associates bingeing with the feeling of being “content”. She says, *“I’m not a comfort eater. I’m not someone who eats when they’re depressed and things,”* adding:

When I’m low of mood, I don’t touch food... But when I’m content or just getting on with life, just leading a normal life, I don’t even have to say happy but just content and just, that’s when I will eat excessive amounts over periods of time.

Eve later reveals that practicing restraint when in a low mood is a way of controlling something when she feels she has lost control of her emotions: *“The only thing that I can control over those periods of time is my eating. So I*

just don't do it." In contrast, *"As soon as I feel in control of other aspects of my life and everything else round me is OK that's when I have my periods of what I call maybe, excessive eating, binge eating."*

Eve's description of her eating is somewhat suggestive of the binge eating sub-type of AN (although she does not meet diagnostic criteria for this) and differentiates her from other participants, who do not have this history of intermittent restraint. This difference may explain why she does not frame her bingeing as a coping mechanism for negative emotions. Yet, contrary to this narrative there are other sections of the interview that suggest a different story. For example, Eve recalls her first experience of bingeing was after *"I was told to leave home"* at 16 due to family fights. She says:

Erm at that time I was actually very depressed. I didn't want, I didn't enjoy being on my own. So I think then the food because it... Well I don't remember.

The unfinished sentence *"because it"* suggests that Eve is pondering what the food offered her, or why bingeing seemed like a good thing to do when she was in the midst of her depression. However, Eve goes on to discuss the food she used to binge on, leaving these suggestive thoughts of mood influence unfinished.

Eve also recounts a recent period of bingeing when she was staying home with her baby son and baking and eating a chocolate cake every day:

I'd be like looking forward to it, erm it was the highlight of my day because I was at home and I wasn't working and boredom. (Slight pause.) I think erm do you know what, I've never actually attached much emotion to... I've never really thought much, I'm not the kind of person who will sit down and eat and eat and eat and think, 'Oh, I'm really loving this.'

There is a hint in this extract that boredom might have been a trigger for the chocolate cake binges, but again Eve moves away from this idea, instead highlighting her lack of feelings about eating.

Eve herself understands her bingeing as being a result of the oppressive environment of food control that she grew up in. She describes her mother as “a health freak, a complete health freak” and says, “growing up we never had chocolates in my house or anything like that. Biscuits – never had that in my house.” She tells stories about how her “mum would freak out if I had like sweets or things like that” and describes how she was engaging in secretive behaviour as early as age 7, buying and eating sweets on the way home and hiding sweets in the shed because eating them felt “naughty” and “I didn’t want my mum to be mad at me.” She talks about how because “my parents wouldn’t let me drink milk because it was fattening” she would sneak downstairs at sleepovers to drink “literally gallons” of their milk, and raid their cupboards for chocolate. If her mum ever caught her eating food she disapproved of, she “had a huge telling off and my mum probably would’ve made me go to the gym or lectured me on health eating. And she’d of been really angry.”

Eve suggests that as an adult opportunity is related to her bingeing, revealing that living alone at age 16 and going to university caused her bingeing to escalate: “When I went to university I put on a lot of weight because I eating like five, six bars of chocolate a day and I didn’t even like chocolate. But I was just eating it because I could.” However Eve does not, in the way some other participants do, talk about opportunities to buy food as themselves being a trigger to binge.

She does, however, explain that her mother not only controlled the type of food she ate but also how much she ate:

She’s always commented, ‘Oh Eve, your eyes are bigger than your belly. Why do you always have to put so much on your plate?’ Or you know,

'Why are you so greedy sometimes?' And there're always constantly going to be those kind of comments.

Even today, she says, *"my mum still now tells me to stop eating,"* illustrating Eve's experience of constant monitoring. In addition, the framing of Eve as *"greedy"* provides a moral judgement on Eve – her eating *"mis-behaviour"* denoting a characterological flaw.

Eve adds that her mother has always commented on her weight: *"She was always so critical of my weight and the size that I was."* When she was heavier she says she felt *"as if my mum was embarrassed of me"* and she recounts how her mother would always comment, *"Oh I can't buy you anything nice now when you look the way you do."* Eve tells a story of how, coming home from university for the first time, having put on weight after a period of bingeing, *"my mum literally she cried when she saw me. My mum cried, got tears in her eyes, and she said, 'Oh my God, Eve, you look awful.' I think she even said disgusting."* It seems that in addition to growing up with a history of food control, Eve grew up with a sense that her body and her weight were under constant surveillance by her mother, with negative judgement being prompted by both weight gain and anything that looked to her mother like *"excessive"* eating.

For Eve, another source of criticism has been her ex-partner, who she says *"called me disgusting and horrible and fat and whatever"* and would also *"have a go at me"* about her eating. However, unlike the others, Eve does not discuss a broader sense of social surveillance of her body and her eating in public spaces, possibly because she has less history of being heavy than some of the other participants. Despite this, she does still employ techniques to avoid social judgment of her food intake. For example, she recounted how she might buy food for herself but pretend it is for her son, and then *"confess"* this strategy (to friends) and *"make a joke out of it"* and *"make it sound like it's something that's not so bad (long pause)."* It appears that Eve defends her

behaviour with humour, trying to make “*bad*” foods into “*something not so bad*”. Eve also talks about how she can binge eat in front of other people: “*I’m not hugely embarrassed of it, and then if I do do it in front of people, like when I’m comfortable around people I will do it*”. The claim that she is “*not embarrassed*” about being seen bingeing is contradicted by her statement that she will only binge in front of people around whom she is “*comfortable*,” suggesting that she does avoid eating “*excessively*” in front of people who might judge her.

There are hints that Eve is trying to manage potential negative social judgement of her binge eating, but there is also an implicit sense in Eve’s account that she has uncritically internalised weight bias. She says that when she put on weight at university “*it was quite upsetting for me because I have always been you know, I... I want to look good you know.*” She also talks about how when she lost weight recently, “*I was getting so many comments on how good I looked.*” It seems that Eve endorses the idea that attractiveness is associated with being slim. Nonetheless there is a sense that Eve is beginning to realise the pressures her mother faces to look a particular way may be related to the control she exerted over Eve. She talks about how both her parents are “*so health conscious and they look good and work hard at keeping trim*” and explains that her mother goes to the gym every day, which she “*has done ever since I remember.*” Unlike any other participant Eve talks about her mother’s own history, how her mother, who had her “*at 20/21 when she was still very self-conscious about how she looked*” was “*always the prettiest girl*” in her “*little, little town*”, to the extent that motorists would drive into lampposts when they saw her in the street: “*she always had a gorgeous body and she always looked good*”. Her father has suggested to Eve that her mother’s own issues with food were the reason for never having sweets or biscuits in her house growing up. Eve also references recent experiences with her mother in which she “*wolfed*” popcorn and ate “*the majority*” of snacks Eve had bought for her son. She says thinking about this history has made her understand

more about how her mother was with her, *“that was her way of controlling her own way of eating.”*

Overall Eve’s account suggests that she is beginning to think about the social context which shaped her mother’s, and now her own, relationship with food yet broadly she appears to have uncritically internalised weight stigma. She does not give the impression that she is subject to negative social surveillance of her body/weight by “others”, although there are hints that she sometimes tries to manage judgement of her food consumption. Unlike other participants, and potentially due to her history of intermittent food restriction, she does not understand her bingeing as being a response to negative affect, however there are still some hints that depression or boredom may play a role. Instead, the main understanding that Eve herself has of her bingeing is that it is *“deep-rooted in my upbringing”* and *“the attitudes of my parents towards me and food.”* This dominant understanding has led Eve to place blame on her mother: *“Because you never let me. Because you controlled what I ate all the time.”* She says: *“I’m just trying to get her to understand that I am the way that I am not because I’m sick in the h-, not sick in the head, but that’s how she sees it sometimes.”* The dysfluency, *“sick in the h-, not sick in the head”* possibly speaks to the distress that comes from having a mother who sees weight gain as not only *“disgusting”* and *“awful”* but also indicative of insanity. The weight of this terrible judgement may explain Eve’s curiosity about the root cause of her mother’s attitudes towards food and weight. However, despite her intense thinking about distal causes, Eve’s account largely fails to consider proximal causes, in other words, why on any given day/time she may begin to binge.

Fran - Fran’s story is unique in the group of participants in that she only started to gain weight in her 40s after historically being thin. However, she too says that her binges were a way to manage negative affect. Fran talks about bingeing in the past when she was *“very low”*: *“when I do get to those low points, I’ll sit there and I’ll go “Right, I want – I’ve got to have something to eat.”* Later in the interview she says, *“I think half of it is boredom but half of it is... Is*

depression, yes.” Fran also talks about how, regardless of how much she eats, “*I don’t ever feel full*” suggesting that she is haunted by a sense that both physically and emotionally she is always “*hungry*”. Fran, who has experienced a long history of depression and also a “*breakdown*” in her 30s, says that historically she would binge if she was “*upset*” or “*tearful*,” stressed or if she experienced “*rages*”:

I’m very calm now, but I used to suffer. I used to be up and down like a yo-yo. You know one minute I would be very calm, the next minute I would be up here. Also when I used to get up there, then to bring me down again, I would eat.

Fran talks vividly about the vicious cycle of guilt about bingeing leading to low mood, which in turn leads to further bingeing:

I’d think ‘God I’ve just eaten all this food.’ And then feel really guilty and really upset about it. So therefore I would think ‘Oh sod it, I’ve done that.’ So therefore I would start eating again because I was still low.

Fran explains her bingeing as being a response to current negative emotions but also in response to an historical lack of self-esteem: “*The comfort eating did start with lack of self-confidence.*”

Across the interview Fran clearly frames her bingeing as her key method of coping with difficult emotions, terming it “*comfort eating*” (discussed further in Theme 2). However she also suggests that sometimes her bingeing would function for her as a way of taking control over her life. For example, she describes how criticism from her sister for letting herself go/putting on weight caused her to binge: “*That wasn’t comfort eating. That was just talking control of something that somebody else was trying to make me do.*” Fran adds that she turned to food as comfort because at the time food was “*the only thing in my life that I had full control over. If I wanted to eat I ate.*” Later in the interview she says; “*This [bingeing] was the one thing in my life I could control. So therefore if I ate as much as I wanted to, therefore I could... You know, I’m my own person now, you know.*” This somewhat grammatically

incoherent sentence is interesting because it implies that bingeing was potentially an act of asserting her own personhood, similar to how she rebelled against her sister's criticism of weight gain by bingeing.

Fran does not talk about opportunity as a potential trigger for bingeing. In addition she does not discuss any history of food control in her family however she does talk about a broader history of criticism and control that she experienced as a child and as a young wife. In fact she directly ties her historical lack of self-confidence to her father: "*If I brought home a report and I got six things that were really good and there was one thing that was bad, he would concentrate on the thing that was bad.*" The results of this upbringing was, she says, that: "*I could never get the self-confidence to do anything.*" Fran also talks about her experience of feeling controlled in her married life: "*I married very young. I felt – nobody was controlling it but it was the way I felt.*" She describes her husband as "*quite a forceful man, do you know what I meant? He's quite forthright*" and says he could not understand how overcome by insecurity she felt.

Fran's bingeing seems to have occurred throughout her life, possibly as a result of traumatic life events such as a miscarriage, an affair, the very difficult sudden death of her affair partner, a "*breakdown*", caring for her sister's child due to her sister's alcoholism, her father's death and now caring for her elderly mother. Across this narrative the bingeing behaviour is tied into what she depicts as an existential struggle for self-identity and self-confidence: "*I didn't know who I was. I was trying to be a mum, I was trying to be the mother, I was trying to be the wife, I was trying to be everybody – the child. But I wasn't being me.*" This narrative suggests that binges give Fran a rare opportunity to be/find herself.

Fran, who is the oldest of the participants, talks less about a sense of social surveillance of fat bodies than other participants, potentially due to being part of a different generational cohort – as she says when she was

growing up “*people didn’t own scales. You didn’t ever look at yourself as being a size whatever.*” However, Fran does talk about her experience of social surveillance of her female body, describing how she was “*quite an attractive girl*” when she was young and “*therefore used to get a lot of attention from men as well as a lot of aggression from women.*” Fran says she started garnering negative comments as she got older and heavier: “*It would be things like, ‘My middle daughter she’s got a weight problem’; ‘My mother-in-law would say ‘Oh, you’re putting a bit of weight on.’*” She also says that after she put weight on “*everybody [at work] who saw me ‘My god, Fran’ you know, You’ve put on a lot of weight.*” In addition, Fran, like other participants, talks about secretive behaviour when buying “*crap*” food, as a way of trying to avoid negative social judgement for her food choices.

Yet, while Fran has clearly tried hard to lose weight – when asked if she had ever been on diets she replied: “*Oh! Every single one!*” – it seems she is ambivalent about weight loss, saying at one point, “*I’m just getting to that age when I think, ‘Oh I can’t be bothered to think about it anymore’.*” Fran also seems ambivalent towards the idea that she should be conforming to a (thin) beauty ideal – she talks about when she was thinner (and younger) not wanting to look “*pretty*” or “*nice*” – “*I wanted people to see me for me, not the image that they had of me.*” Fran implies that being heavier, as she is now, allows her to be herself. Asked why she “*rebels*” against losing weight, she says:

I don’t know what it’s about. I think it’s probably going back to the days when I was slim and I found that people treated me differently to the way that I’m being treated now. I am myself while I’m bigger, whereas when I was slimmer you were somebody for those people. Do you know what I mean? You were a different personality. I wasn’t a different personality – you can’t – I was the same personality but their perception was different.

Fran seems to suggest that both bingeing and being heavier allow her to rebel against social expectations and be “*herself*”.

Unfortunately, Fran's experiences of bingeing have fostered a negative relationship with food and eating, to the point where today, *"I hate food. I actually hate food. I eat because I have to survive. But I've got to a point where I can't bear to look at food."* And while she does not go into detail, she is clearly aware of the broader social surveillance of fat female bodies, a surveillance that she frames as a further trigger to binge: *"You feel very isolated being bigger. That also puts a pressure on you which also makes you eat."*

Overall Fran frames her understanding of why she binges throughout her life as a way to manage negative affect but also as a deeper quest to resolve her lack of self-confidence and establish a sense of self. Fran also ties her bingeing to a history of familial and marital control and criticism, however, a childhood history of food control is not implicated. Finally, Fran does recognise negative social surveillance of fat women's bodies as a potential trigger for bingeing however, for her personally, bingeing and being heavier are places of personal freedom. Presumably as a result, she appears generally unclear about whether she really wants to be thinner or binge free.

Looking across the participants, the analysis suggests that all but Eve understand their bingeing as a way of managing negative emotions. With the exception of Donna and Fran, the others also talk about their bingeing in a way that implicates a childhood history of food control. While Fran does not have this history, she does talk about her experience of a broader sense of being controlled in childhood and in her marriage. There is evidence in all of the participant's narratives of their experience of negative social surveillance of their bodies/weight/eating or food purchasing. This seems to be stronger for both the heavier participants and those with a longer history of being heavier. Fran is the only participant who seems even slightly ambivalent towards the idea that being heavier is bad suggesting that participants are self-stigmatising as well as potentially stigmatised by others. Due to the sense of oppressive negative judgement around their bodies/weight/eating, four of the

participants (not Donna or Eve) seem to experience their binges as the *only* spaces where they can feel free to either eat or be themselves freely.

Despite evidence that the participants did have various understandings of their binge eating behaviour, it is still the case that these understandings seem superficial or unsatisfactory, in many cases to the participants themselves. They talk about their frustration in not understanding why, despite repeated effort, they cannot stop bingeing. For example while the clearest understanding of bingeing in the data is that it is a coping mechanism, none of the accounts, except partly Fran's, sought to provide any kind of clear (deeper) explanation for *why* the participants were struggling with persistent low mood or (in Claire's case) emptiness. While a number of the participants' accounts implicated the history of food control in childhood, only some of the participants made this link themselves, and only Eve's account provided any kind of explanation for why this was the food environment that their parents created. While this analysis has suggested that weight stigma and consequent negative social surveillance (and internalised stigma) may be a causal factor in creating low mood and hence potentiating a context for bingeing, this understanding was largely absent from the participants' accounts, as was the idea that some of them the binges function as a crucially important space of temporary freedom from surveillance and judgement. The participants' understandings of their binge eating behaviour do span different levels of explanation - individual psychological, relational and social - but a coherent and convincing understanding is missing.

Theme Two: Perpetuating and maintaining factors

Theme two focuses on how participants understand why they continue to binge, e.g. their perpetuating and maintaining factors for binge eating, and is broken down into two sub-themes: binges as pleasurable and binges as an addictive. The two sub-themes are reciprocal to two sub-themes in Theme One. For example, in Theme One the participants' identification of negative affect as a proximal trigger for bingeing was identified; the sub-theme 'pleasures of the binge' identifies *how* bingeing lifts negative mood. In Theme One, the sub-theme 'history of food control' identified participants' childhood experiences of having their food intake monitored and controlled, as well as broader themes of feeling controlled in their lives. The sub-theme examined here, 'binges as addictive' examines the extent to which participants as adults do and do not feel 'in control' of their binge as well as the extent to which they explain their BED by labelling themselves as '*addicted*' to food or bingeing. Consideration is also given to participants' beliefs with the analysis seeking to identify 'faulty cognitions' that may function to perpetuate the bingeing behaviour.

As with Theme One, the subthemes are woven into a narrative of each participant, painting an informative picture of how the individual makes sense of what might maintain and perpetuate their binge eating. Presenting the data in this way allows for the individual voices to come through whilst still focusing on the themes, therefore staying true to the tenets of IPA (Braun & Clarke, 2013).

Alice - Alice's account clearly demonstrates how much pleasure she associates with the sweet foods she prefers to binge on. Potentially Alice's binges may be perpetuated by her conviction that sugar, in particular, elevates her mood, something she refers to at one point as "*comfort in sweets and chocolate.*" This belief, which she repeats a number of times during the interview, could be a way to justify her bingeing to both the audience and herself. Furthermore, she comments: "*When I'm depressed I eat, and after... after one chocolate bar I feel happier and relieved.*" In this sentence chocolate is

described as an effective anti-depressant and bingeing on chocolate is framed as a logical response to replace a low mood with a positive one. Alice also discusses the ‘*natural*’ positive mood impact sugar has, substantiating her claim that sugar improves mood and normalising bingeing on sugar: “*And, you know, I do feel great when I eat like loads of sugary things. I think it’s just natural to feel happy after eating.*”

Along with a belief that consuming sugar is a pleasurable mood-lifting experience, Alice also talks about “*treating herself*”, something she uses to position bingeing as a legitimate (and pleasurable) form of self-reward, as demonstrated in the following quote: “*Oh a bad day at work. If I was at home on my own, treating yourself, a night in.*” In this extract, Alice seems to suggest that a binge is a suitable “*treat*” after a difficult day of work. Alice uses the word “*treat*” at four other points in the interview and her positioning of bingeing as being a “*treat*” could be interpreted as a cognition that legitimises and supports her bingeing behaviour.

Alice’s account clearly frames bingeing as pleasurable, rewarding and effective for lifting mood. She also talks about her bingeing in ways that suggest she experiences something addictive in the binge cycle. For example, she describes how in the middle of a binge, she will experience “*all-or-nothing*” thinking that likely exacerbates her bingeing behaviour, namely that once she has “*blown*” her dietary restraint she might as well go all out.

I knew it was bad for me but I just kept thinking (short pause) you know I’ve had two chocolate bars and a packet of crisps, having a doughnut won’t make much of a difference you know to what I have eaten.

Alice here articulates clearly her thinking that once she starts bingeing she “*may as well keep eating*” and “*not stop*”, thoughts associated with addictive behaviours. Yet Alice seems to struggle with the idea of herself as “*addicted*”:

I did think I was like not addicted to chocolate but, you know, couldn’t ever give it up. But I mean at the beginning of last year I went three

months without it and I haven't had chocolate now in four weeks. So I don't think... I'm not addicted to chocolate any more.

Alice's quote suggests uncertainty. In the first sentence she seems to want to say "*I did think I was addicted to chocolate...*" yet in the last sentence the pause and unfinished sentence suggest hesitancy which undercuts the surety of "*I'm not addicted...any more*". This uncertainty is echoed in a later statement about chocolate:

I do miss it now and I do get the odd craving for it but... when I'm in the supermarket, I purposely walk down the chocolate aisle, and not pick something up, so that I can prove to myself I can do it. And I've got a chocolate bar on my mantelpiece at home that just sits there. And if I ever crave it I make myself look at it and just think, 'No. I don't eat it.' And I just think if I can prove to myself that I don't eat chocolate then I don't eat chocolate, so I just can't have...(medium pause) I think once I taste it again I'd want it back so I'm not going to have it.

Alice here uses terms that denote addiction such as '*craving*' and describes how she uses an addiction management strategy of abstinence to stop herself from bingeing on chocolate. The unfinished sentence – "*I just can't have...*" with the unspoken word "*chocolate*" implied - and convoluted logic of "*if I can prove to myself that I don't eat chocolate then I don't eat chocolate*" both however imply a lingering uncertainty about whether she can in fact retain control of her cravings for chocolate, about whether she is in fact "*addicted*" to her binges.

In conclusion, there are a number of factors that may be perpetuating Alice's bingeing behaviour. She describes the pleasure of binge eating, and the narrative of 'treats' provides her with an understanding of bingeing as a pleasurable but also socially legitimate and '*normal*' eating behaviour. There is also in her narrative the idea that she may be addicted to certain foods but she seems uncertain about this as an explanation for her bingeing. Overall her understanding of why she binges (causal and maintenance factors) does not

seem coherent or developed. Alice for example expresses frustration about the fact that she has more than once lost significant amounts of weight only to later put it back on: *“you can just see the weight creeping back on. But I don’t know why I didn’t stop. That’s what really annoys me (short pause)”* It is only when prompted to reflect further on this that she eventually concedes a role for the bingeing: *“That’s the only thing I can think of, is that once I’ve reached that weight I probably thought I could start treating myself again, and it probably overtook and went crazy.”*

Betty - As for Alice, for Betty binges are pleasurable. For example, Betty acknowledges that she experiences positive mood changes from eating chocolate: *“I mean chocolate gives you a high, I love the feeling, the bliss and high.”* Betty also hints towards a feeling of escape when she binges by *“sitting there for the morning”* and watching TV, during which time she also experiences a sense of *“bliss”*. In her account the pleasure that can be gained from bingeing is an obvious perpetuating factor.

Like Alice, who justifies her binges as *“treats”*, Betty made a number of statements that imply beliefs or cognitions which likely support or legitimise her bingeing behaviour. For example, she states that she has a *‘sweet tooth’* (a ‘natural’ preference for sweet food) and appeared to use this to explain why she did not eat vegetables or meals but, instead, tended to go for chocolate and sweets:

I just think I have got a sweet tooth. As I said, not really into meals and I survive like that (pause) by having the sweet stuff rather than the savoury, in a way, no more vegetables (laughter).

Betty’s use of the word *“survive”* suggests the sweet foods she eats, rather than meals and vegetables, provide all the nutrition she needs – potentially (given her history of food control discussed in Theme One) her emotional survival versus dietary needs.

When Betty claims her bingeing behaviour is the consequence of her “sweet tooth” and her brain, she is portraying it as being driven by biological/bodily processes, outside of her direct control:

Why can't I have one bar of chocolate and think 'That was lovely, thank you' and walk away? You know, but I can't and my brain won't allow me to do that.

This is contradictory to Alice, whose binges are likely perpetuated by her belief that once she has “blown” her restraint, she might as well go all out. This belief suggests that Alice experiences some control over her bingeing behaviour even if she does not choose to exert it. Betty, in contrast, laments her loss of control when talking about her inability to stop eating:

The minute I have a [chocolate] bar, I'll be going back for the next one. I won't be able to say, I'll never be able to say 'That was nice, thank you' and walk away.

While Alice was ambivalent about whether she was addicted to bingeing Betty freely admits her belief that she is addicted to food: “*Me, eating my secret so many bars of chocolate a day is no different to drug people, alcoholics, any of them ... Yes, it is, food is an addiction... and I wish more people would see it like that.*” Taken together, Betty’s beliefs position her as having no personal control over her eating in a context in which no food is safe to consume. The consequence of this is that Betty seems trapped, unable to change her relationship with food and, as a result, unable to stop her bingeing behaviour, leading to a perpetual cycle of this behaviour: “*You are caught in a trap. The food is making you feel terrible but you can't stop the food to make yourself feel better.*” Betty’s desperation (and at times she has felt suicidal) is evident when she says that she wishes her taste buds could be permanently removed, or states that “*if I could pay any amount of money to never, ever eat a single food again in my life, I would do it.*”

Betty freely acknowledges she experiences positive mood changes from binge eating and she implies that she fulfils her nutritional and emotional needs with foods consumed during a binge. However, the analysis also suggests that Betty has beliefs that she is a binge “*addict*”, and that she feels trapped, and unable to change her relationship with food or her bingeing behaviour. Betty seems to experience a significant sense of frustration that she does not understand why she binges:

You know, why can everyone else walk around and just say one of something and I have to have several of (small pause). You know, why can anyone I'm with be happy with that one bar, but I'm thinking 'Can I put another bar in the handbag when I'm here that somebody won't notice?'

Why can't I have one bar of chocolate and think 'That was lovely, thank you' and walk away?

Despite her focus on trying to understand why she cannot stop her bingeing, it seems like Betty has not been able to find any answers and certainly many of the perpetuating factors discussed here were not identified by Betty herself.

Claire - Claire (as discussed in Theme One) readily admits her bingeing behaviour could be perpetuated by past events linked to being “*hungry*” and not being free to make her own decisions around food. However, she also talks about the pleasures associated with a binge in a way that suggests that she understands that the positive emotions and feelings she experiences during a binge might be a key factor in maintaining her bingeing behaviour. For example – and in contrast to most of the other participants - she talks about the enjoyment of tasty food as a reason why she binges:

I would enjoy the taste of whatever I was eating, definitely that was top priority. I had to, I had to want it otherwise there would be no point in bingeing on it basically. Umm so taste was, taste is incredibly important,

umm it's sort of anticipation of those tastes and textures and umm, yes tastes and textures basically.

However Claire goes further and details the pleasure she experiences in different phases of a binge. For example, Claire is fully able to describe the positive emotions she experiences *prior* to the binge: “*Or when I'm looking forward to having a binge. It will start off with that sort of anticipation or thoughts about what I could possible go and buy or eat.*” Besides giving her something to look forward to she enters a “*daze*” even during the planning stage of the binge. For Claire, the positives she experiences and the “*excitement*” she feels is so strong she is looking forward to the next binge even before the current one has started:

It's a feeling of looking forward to it....it was a feeling of (short pause) anticipation and sometimes that would be a sort of 'Oh I'll have to do this again'

Claire also describes pleasure *during* the binge as she attempts to describe her binge experience:

In the middle I couldn't tell you what's going on inside my head because it's, it is so far away.....you feel, you feel like you're not, you're not you anymore. You feel...you feel completely umm (short pause) you feel, you do feel completely disconnected from reality. And I think that's the reason why, possibly the main reason why I do it.

Claire here seems to be describing a dissociative state, and she continues on, describing the binge as giving her a “*high*.” She says vividly: “*it feels kind of soft and warm and just far away from reality ... it is like meditating.*” She further states that bingeing is like “*having a hug*” or “*cushiony softness*”. For Claire, achieving a disassociate state during a binge might be experienced as an escape route from negative affect, something positive and healthful, like meditating. Alongside experiences of pleasure and dissociation, the phrase

'like a hug' suggests the binge might also be providing Claire with comfort and connection, something that might be currently missing in her life.

Of all of the participants Claire seems to experience the most positive experiences associated with the binge episode. Further she seems very aware that the pleasure/positives she experiences during a binge perpetuate her bingeing behaviour. For example, in the following passage she claims the binge provides her with a complete escape, not just from her emotions but from herself as well: *"an escape route away from my thoughts and feeling and being me. And that feeling bad about the way I look and it's just an escape from all of that."*

Interestingly, and again unlike the other participants, Claire also seems to experience pleasure *post* binge. Many of the participants talk about how they experience negative emotions post binge, either soon after or the next day. In contrast, Claire says adamantly *"I have never felt guilt afterwards"* adding that that post binge she has a type of *"excitement in a way. A sort of happiness that I was able to, you know, eat and eat more food than I should have done."* Later in the interview Claire does acknowledge that if she is already depressed, *"long-term, perhaps an hour or two after [a binge] or something, it will make me feel worse"* but overall the sense from her narrative is that the attractions of bingeing are a huge perpetuating factor.

Talking about her positive experience of the binge Claire recognises that she might be able to make more sense of her behaviour by talking about it with others:

That's how I understand it. I reckon I could probably understand it better if I talked about it more ummm (short pause) but (short pause) as far as I know right now it is just an escape... (laughter) so yes (long pause)...

The repeated pauses and laughter displayed in this comment could suggest a reluctance to examine her bingeing behaviour. Claire certainly seems to understand that she may be ambivalent about stopping bingeing: *"I am finding it difficult to move on from bingeing. It's not something I can give up*

very easily. And I am not sure when that's going to happen." With everything Claire seems to be gaining from her binge eating it is perhaps not surprising she seems ambivalent about stopping.

Claire seems similarly ambivalent about whether her bingeing behaviour is an addiction. Claire says that: *"the word 'addiction' means, doesn't it, to not be able to give up that thing. For whatever reason."* Claire is not disputing that she binges, but she is not clear if she is choosing to binge (and by implication not binge) or not. Initially she claims she can control her bingeing, but later she says: *"I'm not entirely sure how it works. But it does – it does – it doesn't control me. I do control it, to an extent. But occasionally it does take over."* The see-sawing here (it does/it doesn't) suggests a deep uncertainty about the question of whether the bingeing controls her or she controls the bingeing.

Claire elsewhere uses the language of addiction when describing her bingeing behaviour, for example commenting that if she is unable to binge, she *"will get slight withdrawal symptoms"* and be *"slightly cross and fidgety."* She also directly discusses her binges as an addiction and compares bingeing with other types of addictions. She additionally talks about herself as having *"an addiction to that feeling of fulfilment"* which she gains from binges which is *"very strong"*.

Claire's history of control around food and eating is discussed in Theme One but she also in her interview details experiences of being controlled in other areas of her life as a child/teen (e.g. aspects of personal appearance and school performance). Claire describes her adult and teenage self as *"quite a rebellious sort of person"*; she also at one point uses the word *"rebellion"* to describe a decision to binge. Potentially Claire's history of feeling controlled and responding through *"rebellion"* may be repeating in important ways in her bingeing behaviour – she binges now to take back control she was denied as a child. However these potential explanations for her bingeing are not ones that Claire herself seems (yet) to be making. Instead she talks about being *"incredibly frustrated with myself"* about her inability to stop bingeing:

“There’s one [side of me] that desperately wants to give it [bingeing] up. And there’s the other side that just kind of relents all the time. And just lets me go ahead and do it. I – I can’t....” The unfinished sentence here poignantly captures Claire’s lack of understanding of why – despite wanting “*desperately*” to stop – she continues to binge.

Donna - Unlike other participants Donna says she does not associate pleasure with binge eating, commenting that: *“It isn’t as though (short pause) I enjoy what I’m getting out of it.”* She instead characterises her eating as: *“pure what I would class as gluttony sometimes”* which suggests the influence is more about consuming food rather than enjoyment of taste.

However, Donna shares some cognitions with other participants that likely perpetuate her bingeing behaviour. For example, Donna repeatedly wonders whether the reason why she binges is because doing so provides her with an emotional escape or release:

- *I don’t know if it’s to take yourself out of it or to help you come down.*
- *It’s all, it’s almost as though you do need some sort of release, people’s releases are different. And I suppose mine has been bingeing because I can and it’s always there, all the time.*
- *It’s almost as though you need that punch bag in the corner to go lay into when release... I don’t know it’s strange.*

In these quotes Donna seems uncertain about the idea that her binges function to manage her negative emotions, however she does refer back to this idea frequently, at one point commenting: *“It’s almost like I’ve got to cope with things sometimes, but I don’t want to.”* Donna thus appears to frame her bingeing behaviour as a potential coping mechanism that she uses when she is feeling overwhelmed. Furthermore, she recognises that sometimes she uses this understanding of the purpose of her binges in order to justify them:

It’s almost as though I’ve told myself it’s alright to do it because I am stressed, or you have upset me and (pause) I can do this because (short

pause) I'm sad or I can do this because I'm angry, even though I'm inflicting myself and nobody else.

However, unlike some of the other participants, she also rejects this notion as a legitimate reason to binge: “*It's, i-...it's wrong, I shouldn't be filling my face like that just because I've got an issue with something that's happened in that day. It's pathetic really.*” In the above quote Donna suggests that she should be able to manage her feelings without bingeing; there is a sense of self-directed anger and frustration that she cannot control her emotions or her behaviour. However, elsewhere in the interview, and echoing other participants, Donna frames her bingeing behaviour as an addiction, saying: “*I think when I'm let down and things like that I...I'll just go and turn as people might turn to alcohol would go turn to food.*” The understanding of her bingeing behaviour as an addiction is linked to her sense that she is powerless over her eating when she binges, something that is vividly indicated by the repetitions in the next quote:

I don't know when to stop sometimes, even though I could be full. Just can't stop, can't stop eating. Going to the cupboard, going to the fridge, looking for the next thing. Can't stop.

Here, Donna portrays the relentless nature of her binges, suggesting she uses them to try and satiate feelings that cannot be satiated, implying that this could be a maintaining factor for her behaviour. At one point when talking about a binge episode she comments that the way she is eating is: “*Almost like somebody's going to say you can never eat again.*” In these quotes there is a sense that Donna's bingeing is a response to an internal sense of starvation, however she herself never makes this link and in the interview, she does not talk about what she might be hungering for in her life/self.

In conclusion, Donna understands that her binges serve some positive purpose for her in “*releasing*” or escaping. However, unlike some other participants, she does not report joy in the binges and she further talks clearly

about the harm that binges have caused her, identifying bingeing as a form of self-harm or an addiction. She seems baffled about why she continues to feel the urge to binge and because she cannot understand why she does, she judges herself very negatively. Her lack of understanding of her binges is clear; equally clear is that while she is reflecting a lot on her bingeing history she does not seem to have investigated why she feels so stressed or what she hungers for if it is not in fact food.

Eve - Eve talks about binge eating in a different way to the other participants. Positive emotions and experiences have been suggested as one of the possible maintaining factors for binge eating. This can be seen in Alice, Betty, Claire, and Fran but Eve, like Donna, disavows the idea that binges are pleasurable:

- *I don't actually get any enjoyment out of it.*
- *I, like I said I don't get any great physical – physical satisfaction out of it erm in that sense or any emotional. Not that I, not that I'm aware of.*
- *I'm not the kind of person who will sit down and eat and eat and eat and think 'Oh I'm really loving this, this is...'*

She further elaborates, stating she does not “*feel any excitement*” or get a “*thrill*” out of a binge. At various points of the interview Eve does contradict this, for example referring to binge eating as “*my little enjoyment*” or “*guilty pleasure*”. Yet mostly Eve rejects the idea that she gets pleasure from bingeing.

While other participants have conceptualised binge eating as a response to low affect, Eve (mostly) has not. Rather, as discussed in Theme One, she feels she only binges when she is in a sustained period of positive affect.

Binge eating for Eve seems to be something she does when she is “*content*” and she takes ownership of the binge as “*my binge eating time*”. The idea of a binge as freedom and “*me-time*” suggests a positive valence for bingeing behaviour but, as discussed, Eve denies that binges are pleasurable

for her. Talking about binge enjoyment, she says that she does not want to be seen as “*that type of person*” and the fact she makes this qualification might be significant for her. It is as if Eve is saying that for her bingeing is neither about managing her negative emotions (bingeing thus signifying something negative about her ability to cope) nor about hedonistically enjoying food (an act of excess or gluttony) but is (as further discussed below) rather a positive act of personal liberation. This is quite a distinct understanding from that of other participants.

Like other participants, Eve also talks about her difficulty with controlling her relationship with food in a way that is suggestive of the idea that she is addicted to food or bingeing. She says:

I...I remember that [a period of bingeing at university] being really out of control. I remember just... Why I remember it being out of control is because I was eating things that I wouldn't normally, wasn't... Didn't even really want or like chocolate would make me feel sick but I carried on anyway

She further describes “*periods of time when I just can't stop myself from eating. And I just eat and eat and eat and eat even though I feel sick or I don't really even want it*”. Yet Eve explicitly rejects the idea that she is an addicted to food on the basis that she will not go out and buy food specifically for binges (though elements of her narrative do suggest that she has sometimes done so): “*I'm not the kind of person who will go like an alcoholic who needs alcohol who will go out and buy and seek out the food.*”

Instead of framing it in terms of addiction, Eve explains her lack of control as being a result of her history of food control:

I've grown up in an environment I guess where I've never, it's always been so controlled. And now that there's no one controlling it I can't control it myself....Because I've always had someone else telling me what, you know you've eaten too much Eve, or you can't have that, or you can't have that. So I go through stages when I just eat constantly.

Eve similarly explains her history of bingeing on chocolate – despite the fact she does not really like it – as resulting from the fact that it was a forbidden food when she was a child. She eats it she says not because it tastes good to her but because it is ‘psychologically’ tasty - a guilty pleasure - to eat something “*forbidden*”:

Whereas the chocolate it wasn't something like I said it wasn't, it wasn't something that I would actually choose to eat. But it's something that, I was never really allowed to eat so I...I...I felt guilty. And then you know when you eat something you're not really allowed and then you have it and then you get like a guilty pleasure out of it. Taste bud wise I wasn't like 'Oh yummy hmm.' But psychologically maybe I was like 'Oh I'm eating something forbidden like a forbidden fruit. This isn't something I should be having. This isn't something...' But you feel it's like a forbidden fruit, like a guilty pleasure.

There is a sense here that while Eve experiences her relationship with food as sometimes being out of control that she at the same time she experiences binges as an act of taking control, asserting the autonomy, denied to her as a child, to eat exactly what and how much she wants. When asked what bingeing is for her, Eve responded “...for me it's just because I can...It is literally because I can.” Binge eating is something she is giving herself permission to do and, due to her history of food control, she seems to relish the freedom to be able to choose bingeing.

The contradiction here is that Eve also expresses a strong wish to stop bingeing. She has historically gone through periods of bingeing and periods of food restriction (she uses the phrase ‘yo-yo’ seven times in the interview to describe her “*huge*” weight fluctuations) and she laments that she finds herself unable (despite her expressed wishes) to stop bingeing. Yet Eve herself does not identify this contradiction. Eve differs from other participants in that she does not understand her bingeing behaviour as being perpetuated by the physical or emotional pleasure (or relief) provided by binges, nor the “*addictiveness*” of binges. However like other participants she does not seem in

the end to have a coherent understanding of why she is unable – or perhaps more accurately how - to stop bingeing.

Fran - Fran says: *“I don’t enjoy binge eating. I find it quite distressing to eat that much, but I can’t stop it.”* Yet while Fran denies that binge eating is pleasurable she talks at some length about the way bingeing replaces negative affect with positive in a way that suggests that the positives associated with bingeing are an important explanation for why she binges. Fran describes bingeing as “*calming*” and “*relaxing*”, reminiscent of Claire’s sentiments towards bingeing; she says:

It [bingeing] was suppressing all those feelings and it was – that’s why I say the comfort side comes in. It was actually sort of releasing all those tensions and frustrations and it was just sort of easing it all away.

She further elaborates on the calmness she experiences during a binge, describing it as something that would “*come over me*”, and “*calm the upsetness*”. She says that when she got upset – “*up there*” – she would binge and the physical sensation of fullness would soothe her: “*So internally I’d feel very satisfied – it was almost like... How can I put it in words? It was almost like it was taking all my problems away. It was all easing everything.*” Fran gifts binge eating with providing her with an almost, medicinal relief with its ability to “*take away those feelings of anxiety, stress and sadness*” and acknowledges how it “*suppresses those feelings.*”

As discussed in Theme One, Fran talks vividly about the emotional fallout she has experienced following a bingeing episode yet in a moment when she is remembering how terrible she felt *after* bingeing she is moved to tears by also remembering how wonderful she felt *during*:

I could almost cry now, the way I felt. It’s bringing tears to my eyes because I know how bad I felt when I was doing it, because I felt that I was doing something wrong... It wasn’t wrong – to me it was just something that I did ...for – but this feeling of calmness I suppose, if you want to call it calmness, would come over me.

This quote potentially illustrates why bingeing has been so hard for Fran to give up. Like other participants, Fran sees her binge eating as an addiction, comparing herself at one point to an alcoholic. At another point she says that binge eating for her is “*an addiction because every day I think about food*” saying that when she wakes up every morning she doesn’t think “*What have I got to do today? ‘What day is it?’ Whatever*” but rather “*What mustn’t I eat today?*” Fran also talks about how she experiences loss of control with bingeing, saying she “*can’t stop it. When there is an episode, I can’t stop it.*” However, at another point she contradicts herself, stating the bingeing is not out of control but it is something she “*could stop but you don’t want to stop.*”

As discussed in Theme One, for Fran, food has at points felt like the one thing she can control, something which has led to her (somewhat deliberately?) bingeing after being criticised for her weight: “*That was just taking control of something that somebody else was trying to make me do... going back to ‘I’ll do what I want to do. Don’t tell me what I should be doing.’*” She also reflects on the fact that there is part of her that rejects the idea that she should seek to lose weight: “*I’ve got this constant battle of every time I start losing weight, I almost rebel and then start eating again because that’s my control. It’s really strange.*” Thus, as with Eve, there is a sense that Fran is tangled between experiences of feeling out of control with her binges, like a binge “*addict*”, and feeling that bingeing is a way of taking control back in the context of feeling socially controlled.

Fran says that she has got to the point where due to her issues around food and bingeing: “*I hate food, I actually hate food. I eat because I have to eat to survive. But I’ve got to a point where I can’t bear to look at food.*” Yet while Fran seems insightful when speaking about her binge episodes, it is unclear how aware she is of the contradictions she expresses when discussing her binge eating. She seems to experience genuine distress and a desire to stop bingeing but at the same time there is a sense of not wanting to relinquish the positives she associates with binge eating, such as the calming and comfort it brings her. Equally, while Fran talks about feeling out of control and “*addicted*”

to bingeing, binges have also been a way of her taking back control. Thus, while Fran claims binge eating is a “*battle*” she is “*fighting*” to win, it is not clear if she has a coherent awareness of the factors that may be perpetuating her bingeing behaviour. This may explain why she expresses at one point an uncertainty about whether she will continue to try to stop bingeing: “*I’m just getting to that age when I think Oh, I can’t be bothered to think about it anymore.*”

Summary of Theme Two

The above analysis focused on how the participants made sense of the perpetuating and maintaining factors in their binge eating. It highlighted how for Alice, Betty and Claire the pleasures and positive consequences of bingeing likely act to perpetuate bingeing behaviour. Donna and Fran do not understand their bingeing as pleasurable but nonetheless acknowledged (Donna to a lesser extent) the effectiveness of bingeing in alleviating negative emotions for them. In contrast Eve denied that she binges because she finds it pleasurable or because it reduces negative affect.

The analysis also identified that while all participants talked about experiencing a lack of control around food/in the context of binge episodes, that only Betty, Donna and Fran see themselves as having an addictive relationship with bingeing, with Alice and Claire being unsure whether ‘*addiction*’ explains their relationship with bingeing. The analysis also identified that for both Eve and Fran, bingeing is perpetuated by the emotional experience that it is an important way of asserting personal control. This sub-theme thus potentially sheds light on how a childhood history of food control translates into an adult issue around food control.

Chapter 5: Discussion

The results of this study focussing on understanding how women make sense of binge eating as well as what might be interpreted from their interviews about what triggers and maintains their binges were dominated by two main themes which emerged from the data during the analysis process: (1) the proximal triggers and the distal causes and (2) the perpetuating and maintaining factors. The emergent themes and subthemes reflect the participants 'story telling' about their experience of BED, in which they tended to chronologically unfold their experiences of binges. The data and the resulting themes highlight that binge eating can be understood in terms of three explanatory levels – individual/psychological, relational and societal. Yet the analysis also suggests that participants lack an overarching understanding which connects these explanatory frameworks and which helps them to fully or coherently understand why they, themselves, binge eat. Although the experience of each of the participants is unique, this incomplete or incoherent understanding is a clinically poignant and significant finding. Equally important, the results also highlight how participants, with varying levels of awareness, seem to experience binge eating in a dichotomous fashion, such as both a hindrance and a helper.

The following section discusses the two themes in relation to existing literature and theoretical models. Subsequently, the implications of the findings for practice as well as the profession of counselling psychology will be discussed. A critical evaluation involving reflexive consideration of the researcher's own history on the analysis and considering the limitations of the present study will then be undertaken and recommendations made for future research.

Theme One: Proximal triggers and distal causes

This first theme, proximal trigger and distal causes, is supported by three sub themes, (1) negative mood as a (current) proximal trigger, (2) history of food control in childhood as a distal cause and (3) the sense of social

surveillance around food and eating for the all-female participants as a contextual cause. As such, the analysis considers three potential explanations for bingeing: (1) psychological/individual, (2) relational and (3) social, as well as current and historical influences.

One of the primary concerns all the participants shared was a desire to understand why they binge eat. While the women poignantly described their experiences of trying to make sense of their binge eating, the findings suggest they struggle to identify what triggers them to engage in binge eating in the first place. Overall, the participants seem to have a lack of awareness of their triggers. Given this, when analysing data from the participants, a focus was placed on understanding the triggers both explicitly stated and implicitly suggested when discussing their bingeing.

Negative mood as a (current) proximal trigger

At the individual/psychological level, the study suggests that binge eating is a response to negative affect. The findings also suggest that binge eating is potentiated by a lack of emotional awareness and difficulty with regulation of emotions.

The participants referenced similar negative mood triggers including: low mood, loneliness and boredom, and they explained their bingeing as a way of “*filling an emotional emptiness*” or providing a “*coping mechanism*”. As well as emotional triggers, some of the women highlighted contextual triggers such as opportunity and financial ability, explaining how bingeing, for them, became more prevalent when they were able to buy their own food and be alone. A third class of triggers, mentioned by some of the women, were of a physical nature, such as tiredness and (rarely) physical hunger.

In the extant literature there is agreement that binge eating is a response to both emotional and physical states, and like the participants in this study, the research suggests binge eating patterns in response to these states or triggers can vary significantly between individuals (see Vanderlinden, Dalle-Grave, Vandereycken & Noorduin, 2001). Nonetheless, there is a

commonality between what the participants of this study identified and what the existing research suggests about the role of negative mood and physical state in BED. Binge eating emotional triggers for women suggested by the research include: depression or sadness, anxiety or feeling tense, boredom, loneliness, feeling unloved, feeling like a failure, frustration and anger (Fassino et al., 2003; Hudson et al., 2007; Nicholls et al., 2016; Rosenbaum & White, 2013; Wilfley et al., 2000; Zeeck et al., 2011). Food and eating-related triggers identified in the literature include: being in the presence of a certain type of food, urges to eat sweet foods, skipping meals earlier in the day and physical hunger (Haedt-Matt & Keel, 2011; Vanderlinden et al., 2001; White & Grilo, 2005). One physical state/symptom identified in the literature for women was pre-menstrual cravings (Algars et al., 2014).

The research suggests the importance of negative mood in BED. The binge eating triggers most frequently reported and at the same time having the highest level of discomfort (as self-rated by individuals with BED) were also found to be emotional triggers (Vanderlinden, et al., 2001). Consistent with this understanding, most of the participants make the link that they binge as a response to negative affect or emotion, emphasising the salience of this experience/relationship. The understanding that negative emotions are a trigger for a binge however is not shared by Betty or Eve, as both categorically deny that their bingeing is a result of negative emotions or mood. Yet nonetheless both women's narratives firmly implicate low mood as a trigger for bingeing behaviour.

The research suggests a particular role for anxiety as a common trigger for eating (Schneider, Appelhans, Whited, Oleski & Pagoto, 2010; Schneider et al., 2012). Stress has been found to negatively impact eating in the absence of hunger and lead to the overconsumption of sweet foods (Michels et al., 2014). Furthermore, Michels and colleagues (2014) and O'Connor, Jones, Conner, McMillan and Ferguson (2008) noted the importance of psychological stressors in binge eating and stated that psychological stressors occur "*when the demand of a situation exceeds an individual's ability to cope and resolve the*

problem, resulting in emotional, behavioural and cognitive disturbances" (2008, p.40). In other words the authors identify that binge eating functions as a form of coping when a person feels anxious.

Various studies find that negative emotions including anxiety and like the ones experienced by the participants, are antecedents to the bingeing process in bulimic patients (Eldridge & Agras, 1996; Grilo, Shiffman & Carter-Campbell, 1994; Meyer & Waller, 1999; Powell & Thelen, 1996; Stickney, Mittenberger & Wolff, 1999). While BN and BED are distinct conditions, research exploring the antecedents to the binge specific to BED have reached similar conclusions, that negative emotions can trigger a binge (Kittel et al., 2015; Lavender et al., 2015). Researchers have also found that the severity of a binge is strongly associated with the severity of the negative emotions being experienced (Zeeck et al., 2011).

Overall, the evidence from this study and others provides support for the Affect Regulation Model for BED (Deaver et al., 2003; Haedt-Matt & Keel, 2011; Kobal, Meers, Storfer-Isser, Domoff & Mushner-Eizenman, 2012; Mason et al., 2017). The affect regulation model posits that binge eating is: (1) triggered by negative affective states and; (2) serves to regulate negative affect. Research in support of this theory has found that binge eating functions as a coping strategy for reducing aversive states by providing short-term distraction and relief from negative stimuli (Arnow, Kenardy & Agras, 1992; Heatherton & Baumeister, 1991; Polivy & Herman, 1993; Wisner & Telch, 1999), a finding supported by the current study. Further, recent literature around the affect regulation model for binge eating suggests that individual affect fluctuations and context of the binge are important (Berg et al., 2013; Berg et al., 2017), which may explain why evidence (typically built from samples including individuals experiencing both BED and BN) for the affect regulation model is mixed (Haedt-Matt & Keel, 2011). One potential difference between BN and BED is that while for individuals with BED it is the binge that functions to improve mood, for those with BN it is purging that provides alleviation from negative affect (Jeppson, Richards, Hardman & Granley, 2003;

Tashi, Murakami, Murotsu, & Washizuka, 2001; Witt & Lowe, 2014). The affect regulation model, focussed as it is on the binge process (versus processes related to purging) may thus be more applicable to BED than BN. Yet currently the vast majority of the studies on this model are not specific to BED so this is something that remains to be established.

The findings also support emotional regulation theory, which suggests an individual with BED will have wide-ranging difficulties in emotion regulation, including reduced impulse control, poor emotional awareness and clarity, and lack of emotion control strategies (Kittel et al., 2015; Lavender et al., 2015). Previous research has shown support for the emotional regulation theory (Kittel et al., 2015; Lavender et al., 2012; Lavender et al., 2015; Zeeck et al., 2011). Robinson, Safer, Austin and Etkin (2015) have further suggested that *implicit* emotion regulation – emotion regulation occurring outside of awareness – is overlooked, but relevant, to understanding the role emotions play in binge eating. In line with this literature, the women in the present study all seem to be experiencing some level of poor emotional regulation and poor impulse control in response to their emotions. Further, the linguistic dysfluencies which are shown most clearly by Betty and Claire suggest emotional incoherence and reduced emotional understanding, which may indicate that binge eating is a form of emotion coping strategy that operates at least partly implicitly or outside of full awareness.

Interestingly, and in contradiction to the affect regulation model and emotion regulation theory, one participant, Eve, in the present study mentioned *good* mood as a trigger for her bingeing, explaining that when in a low mood, and not in control of her emotions, she exerted control over her eating, however, when in a good mood, she would allow herself to relax or 'lose control' of her eating. Although the relationship between emotions and binge eating has been extensively investigated, the majority of this research places emphasis on negative emotions (Greeno & Wing, 1994), a point made more recently by Braden, Musher-Eizenman, Watford and Emley (2018). The fact that Eve understands her proximal triggers for binge eating to be the

emotional state of being 'content' suggests that it is problematic that research into positive emotions as triggers for binge eating has been relatively neglected, despite a number of theoretical indications for them being an important consideration (Evers, Adriaanse, de Ridder & de Witt Huberts, 2013).

Alongside the emotional triggers that the women in the present study refer to, they also mention contextual triggers, such as the opportunity and financial ability to binge. All of the participants say their binge eating most always occurs when they are alone; additionally, some of the women share experiences of how leaving home and having their own money to spend gave them the 'freedom' to purchase food without judgement or restriction and to binge without the fear of being caught. Although most of the participants clearly identify how these contextual triggers, leaving home and having freedom and control to make their own decision around food influenced their binge eating, there is very little research that has sought to explore the role of 'opportunity' factors in BED. The results of this study suggest the value in investigating 'opportunity' triggers because participants' accounts suggest that more opportunities for bingeing tended to be associated with an escalation in bingeing behaviour in which a new-found freedom and control around food led to out-of-control behaviour with food and an experience of the food, perhaps, controlling them.

The third, and final, category of triggers mentioned by the women in the present study were those of a physical nature. This category includes physical hunger (although only for one participant) and tiredness. Berg et al. (2013) suggested a link between the decision to (binge) eat, and tiredness and negative affect, theorising that when stressed the mind may misinterpret cognitive exhaustion as a physical tiredness and attempt to regain balance by supplying the body with additional energy i.e. through binge eating. Similarly, the way that participants describe these physical states suggests that they are emotional as well as physical. Claire for example talks about looking for a feeling of "*fullness*" because she feels "*empty*" as if she has a hunger for

something that she just ‘can’t satisfy.’ In accord with this, Eli (2015) suggests that binge eating is associated with an experience of existential emptiness in which binge eating provides an illusory relief.

The idea that individuals experiencing BED may be using binges to manage a core emotional hunger (a long-standing and deeply rooted negative affect) is not an understanding expressed by the participants of this study. Instead, as discussed, the impression is that while the participants were able to easily link day-to-day experience of negative affect to binge eating they lacked a deeper understanding of why they might be feeling bad. Lack of emotional awareness is suggestive of alexithymia (difficulty in identifying or expressing one’s feelings) and research has found associations between alexithymia and BED. For example, alexithymia was found to predict eating in response to negative affect in people with BED (Pinaquy, Chabrol, Simon, Louvet & Barbe, 2003) and was also found predictive of more severe BED (Carano et al., 2006). Barth (2014) has suggested that individuals with alexithymia and eating disorders are often hard to recognise because, like the women in this study, they can be “*extremely bright and articulate and speak freely of their feelings and both the current context and historical explanations for them, so it is often not obvious that their words are not helping them process emotions.*” (2013, p34) Barth’s words potentially help to explain why, despite the evidence that the participants did have various understandings of their binge eating behaviour, it is still the case that these understandings seem superficial or unsatisfactory, in many cases to the participants themselves.

In conclusion, the present study provides support for the extant literature on binge eating triggers, particularly for the role of negative affect but also for the role of physical states. However, unlike many other investigations of binge eating triggers, the present study also provides some evidence (from one participant) for the effect of positive emotional triggers. In addition, this sub-theme illustrated the role of opportunity triggers which are little explored in the current literature.

Family and a history of previous control surrounding food

The explanation for their binges that seems to have been most readily available to the participants of this study was that they binged in response to (superficial, temporal) negative emotions. The next two sub-themes present understandings of binge eating that were, overall, less obvious to the participants themselves.

The results of this study suggest food control experienced as child may be a trigger for bingeing behaviour in adulthood for some of the participants. (Participants who did not report childhood experiences of food control instead reported other experiences of feeling controlled.) Participants' accounts described how in their childhoods food was controlled, restricted and monitored not only by family members but other adult authority figures. Generally speaking, the participants seem to have been taught, or to have accepted the premise, that food is something that needs to be controlled and restricted. Some of the participants talk about the experiences of being "*forced*" to eat particular types of foods which resulted in avoidance in adulthood. For others, types of foods were severely restricted or not allowed at all, resulting in certain foods being thought of as '*bad*' or '*naughty*' and creating a mind-set wherein food is framed as either good or bad. Participants did not just experience control around types of food but also in terms of quantity, with a regime of food restriction and/or support for dieting for many participants.

In support of the findings of this study, there is research evidence for the idea that childhood history around food/eating is important in the development of BED. The literature suggests that parents and families are a critical influence for an individual when establishing models for eating behaviour (Senra, Sanchez-Cao, Seoane & Leung, 2006), and that unhealthy eating attitudes and behaviours during childhood often manifest later in life as disordered eating behaviours (Ashcroft, Semmler, Carnell, van Jaarsveld & Wardle, 2008; Mikkila, Rasanen, Raitakari, Pietnen & Vikari, 2015). Further, Rommel et al., (2012) propose when children experience parental control and

judgement around food this may lead to a reduction of emotional awareness which (as discussed), when heightened later, can trigger binge eating.

One participant (Eve) talked about the realisation that her mother may have had some issues around food. Certainly, the literature on parents with eating disorders (ED) (a literature mostly and arguably problematically focused on mothers) provides further evidence that a family culture around food/eating – here as evidenced by parental ED status – has an impact on children’s relationships with food. Studies have shown that mothers with an ED history are more likely to have children with feeding difficulties, and that they are more likely to restrict their child’s eating and use food for non-nutritive purposes (e.g. distraction or reward; Agras, Hammer & McNicholas, 1999; Koubaa, Hallstrom & Hirschberg, 2008; Micali, Simonoff & Treasure, 2009; Reba-Harrelson et al., 2010; Stice, Agras & Hammer, 1999; Waugh & Bulik, 1999). This literature highlights the importance of the interactions between a child and their primary caregiver during the developmental stages of their life in potentially establishing how the child relates to food as they grow. In another study, maternal concern about child weight and maternal education were significant predictors of child eating disorder psychopathology, children’s family satisfaction scores were significant in predicting loss of control in terms of eating, family exposure to stressful life events was significant in predicting emotional eating, and maternal concern about child weight was significant in predicting dietary restraint (Allen, Gibson, McLean, Davis & Byrne 2014). A study by Lee et al., (2018) further found that poor family functioning, particularly feelings of loneliness, isolation, frustration and embarrassment, contributed to the development of BED. Such research is in line with the accounts of the women in this research in the way in that they suggest the complex relationships that may exist between the family emotional environment, the struggles of parents around their own relationships with food/weight, and the development of less healthy food/eating patterns in children.

An additional factor suggested by the research is trauma. Childhood trauma, emotional abuse in particular (Moulton et al., 2015), has been linked to the development of BED, both in childhood (Palmisano et al., 2018) and adulthood (Moulton et al., 2015), and is considered a strong predictor of the prevalence of bingeing episodes in BED sufferers (Smyth, Heron, Wonderlich, Crosby & Thompson, 2008). It is thought that negative remarks made against a child (e.g. about their '*greek*' or body shape/weight), as part of the emotional abuse against them, can cause them to view themselves more negatively as they develop into adulthood (Dunkley, Masheb & Grilo, 2010). In the present study, none of the women refer to childhood trauma when discussing their binge eating, however they were not asked about experience of trauma in the interview so it is possible that this might be an explanatory factor for some of the women. Several of the women did however recount negative remarks made about them made by family members and it does seem plausible that this history might have led to more negative self-judgement in adulthood. The relevance of this type of history is further discussed in the next sub-theme.

The participants' history of food control can also usefully be understood as 'loss of control' when a person starts to eat which is a core diagnostic feature of BED (APA, 2013, p.550). For the participants in this study, the loss of control could be understood as both a response to the restraint around food which historically was placed upon them, and also as a way of trying to establish, albeit unsuccessfully, control around food which was previously not allowed. In line with this, Hernandez-Hons and Woolley (2012) argue that bingeing can be seen as an attempt to regain control over food following a history of food control by parents. In an early study, Ogden and Wardle (1991) found that those who restricted food intake were more likely to experience a sense of defiance and rebelliousness and therefore consume previously restricted foods in high quantities, unlike unrestrained individuals who were less likely to over-eat. The findings of this study – in particular the notion of bingeing as a 'rebellion' – resonate strongly with the narratives of certain of the women in the present study.

In addition to talking about their *childhood* histories of food control, the participants all talked about their histories of dieting as *adults*. The accounts of childhood histories of food control and encouragement for food restriction and dieting as children/teenagers may suggest some support for Restraint Theory in terms of BED (Herman & Polivy, 1988). Restraint theory postulates that dieting can provoke “*feelings of deprivation*” (Theim & Wilfley, 2009, p.192) which lead to hunger which then provokes bingeing (Polivy & Herman, 1993). Potentially a childhood history of dieting/food restraint may set up a pattern whereby a sense of deprivation leads to bingeing in response to any experience of hunger. Yet restraint theory is more focussed on current experience of dieting and less on the long-term impacts of childhood experience of food control. As a result, several authors suggest that this model does not provide a satisfactory explanation for the dieting behaviour in adults with BED (Castonguay et al., 1995; Santonastaso et al., 1999; Wilson et al., 2002; Ochner et al., 2009).

A potentially more satisfactory theoretical explanation for the causal relationship between a childhood history of food control and the development of BED is provided by psychodynamic theories around binge eating. Psychodynamic theory provides a *relational* as well as *individual* model of explanation, which focuses on the distal (historical) influences on binge eating from childhood. Psychodynamic theory views the behaviour of binge eating and food itself as fulfilling an intrapsychic purpose (Burch & Siassi, 1973), and as a way of communicating or expressing underlying issues (Zerbe, 2001). In this conceptualisation, although maladaptive, the development and function of binge eating occurs as a direct result of needs that were not met during a person’s development. The binge eating behaviour serves to substitute for developmental relational deficits and to protect against the resulting pain, anger and frustration (Burch & Siassi, 1973). Thus, tying in with sub-theme one, this behaviour is understood as a coping mechanism for negative moods and emotions, and as a way of neutralising anxiety or stress (Winnicott, 1945). However, the maladaptive functions (binge eating behaviours) do not resolve

the underlying deficits. This means that an individual who never learned the ability to self-soothe, may use food as a means of comfort and may binge eat when upset, but in doing so will perpetuate a situation in which they do not learn to self-soothe (Burch & Siassi, 1973).

Psychodynamic theory also posits that disordered eating emerges in response to particular relational deficits, particularly those relevant to caregivers in childhood, as described in attachment theory (Hernandez-Hons & Wooley, 2012; Hertz, Addad & Romel, 2012; Wilkinson, Rowe, Bishop & Brunstrom, 2010). Attachment theorists propose that emotional hunger is explained at the core by a deep craving for safe and nurturing relationships which were lacking in infancy and childhood due to insecure attachments with parents/caregivers (Pace, Cacioppo & Schimmenti, 2012; Tasca & Balfour, 2014). Attachment theory also posits that insecure attachment is associated with poor emotion regulation and for BED this link is empirically supported by a study which found that difficulties in emotion regulation mediated the relationship between insecure attachment and binge eating (Shakory et al., 2015). Yet although there seems to be a convincing theoretical and empirical link between attachment and eating disorders, there is also clear evidence not all people with eating disorders have had poor or traumatic attachment experiences (Barth, 2014). This may help explain the different experiences of the participants in the current study.

In summary, this section has considered the theoretical and empirical evidence for the findings of this study that the role of a childhood history of food control may be implicated in the etiology of binge eating disorder (or more broadly maladaptive relationships with food/eating), as well as the potential role of maternal issues around food as highlighted by one participant. In addition to considering the research on how an unhealthy environment around food and eating in childhood may translate into ED in adulthood, this section has outlined the potential broader contribution of childhood experience of trauma, and relational deficits with parents, in particular insecure parent attachments. From the review of restraint theory,

psychodynamic conceptualisation of BED and attachment theory related to BED it is clear that there is a number of theories – albeit without necessarily a great deal of empirical support - that provide plausible explanations for why binge eating might emerge as a behaviour in adulthood. In particular the conceptualisation of connection between a lingering emotional deficit related to childhood insecure attachments to parents and the urge in the here-and-now by adults to binge, provides a compelling understanding of why participants might sometimes find themselves compelled to eat and eat. Yet this understanding – that they are erroneously seeking to satiate a deep emotional craving with food binges – is not one any of the participants themselves had.

Social surveillance and stigma

The sub-theme of history of food control proposed a relational explanation for the development of binge eating. This sub-theme considers societal factors that may explain why some individuals develop BED. The study findings suggest that weight stigma and associated negative social surveillance (experienced or anticipated) of the participants' bodies, appearance and weight, as well as internalised stigma, may be causal factors in creating low mood and hence potentiating a context for bingeing.

The participants often talk about the experience of “*being watched*” and how “*doing things they shouldn't do*” around food results in a sense of being judged which in turn contributes to them not feeling “*normal*”. Tischner's (2013) discursive analysis of the experience of being fat identifies that her ‘large’ participants report a similar experience of being under constant surveillance, in particular in terms of their eating and food purchasing behaviour. However, there is a lack of qualitative research with individuals who meet criteria for BED and thus this study provides an important potential link between the experience of being surveilled and binge eating behaviour, as the study results suggest that bingeing may be encouraged by the fact that the experience of eating is often so uncomfortable due to the experience or fear of social judgement.

In the current study, in a bid to negate and free themselves from this perceived judgemental atmosphere virtually all the women go to great lengths to binge in private, alone and or in secret. Bingeing alone is actually part of the diagnostic criteria and strongly supported as a key facet of BED by the literature (Fairburn, 2008; Masuda, Boone & Timko, 2011). More importantly however, the findings of this study suggest there is more to be understood about this need to binge alone, away from the gaze of others – potentially that the solo behaviour evolves in response to the need to escape the negative judgement some individuals experience from society on account of their weight/shape. Extrapolating from this point it is useful to draw on the literature on ‘weight stigma’. However, in considering the research in this area, it is important to note that BED sufferers potentially belong to two groups that are subject to stigmatisation; on account of their ‘excess’ weight as well as for their mental health diagnosis (Roberto et al., 2016).

Weight-based stigma and discrimination are prevalent across the world (Brewis, Wutich, Falletta-Cowden & Rodriguez-Soto, 2011) and stem from a society-wide stereotypical beliefs that obese individuals are weak-willed, lazy, unintelligent, sloppy, lacking in motivation to improve health and lacking in self-discipline (Ambwami, Thomas, Hopwood, Moss & Grilo, 2014; Brochu & Esses, 2011; Hayran, Akan, Ozkan & Kocaoglu, 2013; Sikorski et al., 2011). Researchers have demonstrated the significant impact that experiences with weigh stigma can have on individuals with obesity, which can include psychological impacts (e.g. lowered self-esteem), physiological stress responses (e.g. increased cortisol), and behavioural impacts (e.g. decreased motivation to engage in health behaviours)(Tomiyama, 2014; Vartanian & Smyth, 2013). These stereotypes are present in many settings, including the workplace, educational establishment, health-care facilities and the media, leaving overweight individuals vulnerable to unfair treatment and manifold stigmatisation (Brownell, Puhl, Schwartz & Rudd, 2005; Puhl & Heuer, 2009).

Weight stigma has clear and negative impacts on individuals, as any experience of stigma might be expected to. However, ironically, there is

accumulating evidence that weight stigma makes it more likely that a person will become (more) overweight or obese. Thus, there is research that would suggest that weight stigmatisation is a risk factor for the development of obesity, maladaptive eating behaviours and eating disorder symptoms (Almeida, Savoy & Boxer, 2011; Durso, Latner & Hayashi, 2012; Eisenberg, Berge, Fulkerson & Neumark-Sztainer, 2012; Krug et al., 2013; Olvera, Dempsey, Gonzalez & Abrahamson, 2013; Sutin & Terracciono, 2013). Potentially the findings of the current study provide some clues about *how* weight stigma may operate to increase weight/potentiate unhealthy eating behaviours, namely by increasing the urge to binge when alone and outside of contexts where eating behaviours may be negatively judged by others.

There is some research which has investigated the relationship between weight stigma and BED, which has shown a positive correlation between the belief that BED is caused by a lack of self-discipline and the propensity to express weight stigma (Ebner, Latner & O'Brien, 2011). This study, found that compared with AN and BN, BED sufferers are considered to possess the least amount of self-control, but – contrastingly – are seen as less impaired and more trustworthy (Ebner & Latner, 2013). This conflict in opinions demonstrates the lack of awareness and understanding people have regarding eating disorders and highlights the need for continual research and education on the topic. Yet this research also provides some additional external validation of the reports by participants in this study about their experiences or perceptions of weight stigma.

The findings of this study suggest that participants' experience or fear weight stigma from others. As discussed above there is a (growing) body of research on the existence and impacts of weight stigma but with some exceptions such as the Ebner and Latner (2013) study discussed above this literature is not focussed on BED. The current study thus provides important information about how women who meet criteria for BED experience and are impacted by weight stigma.

While there is little research on how weight stigma from *others* impacts those with BED, there is a growing literature on how weight stigma that is *internalised* by a person impacts the person. In this study, many of the participants appear to have internalised the negative stereotypes of 'weight stigma' and it is possible that this internalised stigma is a contributing factor to their binge eating. Various studies suggest intrapersonal (internalised) weight stigma (IWS), in which individuals begin to internalise negative societal weight biases and blame themselves for the stigma they confront, is predictive of binge eating (Durso et al., 2012; Puhl, Moss-Racusin & Schwartz, 2007). Further, and supporting the findings of this study, experiences of weight stigma have been found to be associated with greater weight bias internalisation, which was, in turn, associated with greater psychological distress and more disordered eating (O'Brien et al., 2016). Relatedly, two studies focused on patients attending weight loss clinics, found that IWS has the potential to increase binge eating (Burmeister & Carels, 2014; Carels et al., 2013). Other studies focused on individuals with BED have found positive relationships between IWS and depression, eating pathology and negative relationships with self-reported health and self-esteem (Durso et al., 2012; Pearl et al., 2014a, 2014b). Potentially the relationship between internalised weight stigma and disturbed eating is complex, as another study found that IWS mediates the relationship between perceived discrimination and eating disturbances (Durso et al., 2012). Overall however – and in line with the findings of this study - the research suggests that IWS is another important factor in the development or maintenance of BED.

One question that arises related to internalised weight stigma is what makes individuals more vulnerable to developing IWS. It is notable that many women in this study experienced judgement from their family around weight and eating both while growing up and in adulthood; moreover, the participants at times in their interviews seem to be struggling to defend against comments made by family members around weight, both gain and loss, suggesting a potential internalised acceptance of a critical family voice or

family weight stigma. Thus, one idea is that history of experiencing weight stigma from family members may be important in the development of IWS. In support of this, evidence from a large predominantly female survey (>2,500 adults) suggests that family are the most frequent source of weight stigma (Puhl and Brownell, 2006). As discussed above Dunkley et al., (2010) suggested that a childhood history of emotionally abusive comments around the self in relationship to food or weight might be a causal factor in the development of BED; potentially IWS is a mediating factor here. Womble and colleagues (2001) also showed that a history of teasing, especially weight-related, by parents and peers, was associated with binge eating later in life, a finding echoed by many studies since (Benas & Gibb, 2008; Goldfield et al., 2010; Quick, McWilliams & Byrd-Bredbenner, 2013). The findings of this study thus suggest that potentially a childhood history of experiencing weight stigma from family may contribute to the development of IWS and in turn potentiate the development of BED.

In summary, the findings of this research – namely that women who binge eat perceive social weight-related judgement on their eating in public spaces and that they talk in ways that suggest that many of them have internalised weight stigma – accords with the growing research that points to the role of weight stigma, from others as well as internalised, in potentiating bingeing behaviour. This conclusion evokes a broader question, which is beyond the scope of the current thesis, about how to understand the phenomenon of weight stigma in society. ‘Fat studies’ (e.g. Rothblum & Solovay, 2009) and feminist theorisation around body shape/weight (e.g. Bordo, 2004; Farrell, 2011; Riley, Burns, Frith, Wiggins & Markula, 2008; Saguay, 2012; Tischner, 2013) seek to unpick the reasons for an apparently obsessive social focus on regulating in particular female bodies in terms of their weight, shape and appearance as well as the societal focus on denigrating fat, as indicated in the widely accepted notion of an ‘obesity epidemic’. A summary of this important critical literature is beyond the scope of the current work but the key point for the current argument is that this literature

supports the idea that societal factors are likely also important in explaining BED both as a social phenomenon and phenomenologically, as a personal experience. This literature also suggests the explanatory value of research such as the current study which, in contrast to the majority of the research on BED, is qualitative, dubious about the underlying assumption of a positivist epistemology, and also 'critical' (e.g. about diagnosis).

Conclusions for theme one

In summary, the main finding of theme one is that the participants' understanding of their binge eating behaviour spans different levels of explanations, individual psychological, relational and social but that for participants' a coherent and convincing understanding is missing.

Theme Two – Maintaining and Perpetuating Factors

The second theme, maintaining and perpetuating factors, is supported by two sub-themes, (1) pleasures of the binge and (2) binges as addiction. This theme focuses on how participants understand why they continue to binge eat and explores how they make sense of their maintaining and perpetuating factors.

In line with the findings of theme one, it emerged from the data the participants seem to have both a considerable frustration around not being able to understand why they continue to binge eat (even when they wish not to) but also a lack of awareness of what maintains and perpetuates their binge eating – the function it serves. Given this, a focus was placed on examining what the participants understood about this, both explicitly stated and implicitly suggested when discussing their bingeing.

Pleasures of the binge

As discussed in theme one, all the participants seem to identify negative emotion as a trigger for binge eating. The theme ‘pleasures of the binge’ seeks to understand how or why binge eating is a coping response for negative mood and, thus, what contributes to the maintenance of binge eating.

The key finding of this sub-theme is how, once triggered, a binge eating episode, is for the participants generally framed, and understood, as a legitimate, natural, and pleasurable mood lifting experience. Even for Donna and Fran who directly claim they do not associate pleasure with a binge episode, their narratives and cognitions suggest otherwise. This understanding of binges potentially reinforces and thus contributes to the maintenance of the bingeing behaviour. Importantly though, while most of the participants’ accounts show this, they themselves have not necessarily made the connection that the positive emotions and feelings they experience during a binge might be a key factor in maintaining their bingeing behaviour.

The analysis further suggests that it is important to understand the bi-directional relationship between triggers and the experience of a binge, and the potential that pleasures experienced while bingeing (say on a particular food) may develop new binge triggers (e.g. seeing that food in a shop). Relatedly, the finding of a narrative for some participants of binges as “*treats*” and “*guilty pleasures*” – an understanding which serves to justify and legitimize bingeing – suggests that anticipation of pleasure may itself become a binge trigger and that binges may, as suggested by one participant, be triggered by positive emotion and not just negative.

The idea that binge eating is triggered by a desire to avoid negative affect or emotion is widely accepted in the literature as articulated by various models (e.g. escape theory, affect regulation model and the emotion regulation model; Heatherton & Baumeister, 1991; Lavender et al., 2015; Polivy & Herman, 1993). Theoretically bingeing is understood to reduce the impact of emotions and thus provide emotional regulation (Zeek et al., 2011; Dingemans, Danner & Parks, 2017; Kittel et al., 2015). The existing research also suggests that the purpose of the binge has significance, with the experience of pleasure seemingly dependent on the individual and of the context of that specific binge (Jeppson et al., 2003; Tashi et al., 2001; Witt & Lowe, 2014). Just as binges are triggered for various reasons, so a binge might serve as a metaphorical anti-depressant one day and an ‘escape’ the next. In other words, binge eating behaviour varies individually but also temporally, with the binge potentially serving multiple “*pleasure*” functions which vary across time and context (Eli, 2015; McManus & Waller, 1995).

The study findings also suggest that one of the ‘pleasures’ of a binge is the offer of an ‘escape’ from low mood which was described by several of the participants in ways that suggested that binges help them experience a dissociative state – helping them feel “*fuzzy*” or even “*high*”. This echoes research which finds that bingeing provides escape from negative emotions through a dissociative state (Austin, 2013; Moulton et al., 2015). For example, studies have found that dissociation rates are higher in BED sufferers

compared with healthy controls (Palmisano et al., 2018; Vanderlinden, Vandereycken, Van Dyck & Vertommen, 1993). Further, some research has found that dissociation is one of the best predictors of the frequency of binge episodes (La Mela et al., 2010), as well as, for women with BN, binge episode severity (Everill, Waller & MacDonald, 1995; McCallum, Lock, Kulla, Rorty & Wetzel, 1992; Vanderlinden et al., 1993). Such research suggests that dissociation serves a strong function in maintaining binge eating.

The idea that a key ‘pleasure’ of binge eating is the dissociation it promotes also supports escape theory as an explanatory framework for binge eating disorder, as escape theory views binge eating as an attempt to escape from self-awareness, consequent to experience of negative affect, and as providing a way of coping with and regulating emotion (Burton & Abbott, 2017; Heatherton & Bauminster, 1991; Higgins, 1987). This sub-theme also evidences the second hypothesis of the affect regulation model, namely that binge eating is (1) triggered by negative affective states and (2) serves to regulate negative affect (Deaver et al., 2003; Haedt-Matt & Keel, 2011; Kobal et al., 2012; Mason et al., 2017) by providing a distraction from the stimulus (Stice, 2001). Based on this theory, bingeing is perpetuated by negative reinforcement (due to the reduction of the negative stimulus), which occurs as a result of the binge process becoming a conditioned response to negative affect based on the positive outcomes associated with the binge (Pearson, Wonderlich & Smith, 2015). This understanding of bingeing as a conditioned response may potentially explain the struggles described by the participants to stop their bingeing. Research supports the affect regulation model for BED (e.g. Arnow et al., 1995; Heatherton & Baumeister, 1991; Polivy & Herman, 1993; Wisner & Telch, 1999) and the study findings of considerable variation in how the women experienced the ‘pleasures’ of their bingeing also support the more recent literature around the affect regulation model for binge eating that individual affect fluctuations and context of the binge are important (Berg et al., 2013; Berg et al., 2017).

In summary, the existing literature around BED, and eating disorders more broadly, provides some support for the understanding by some women in the study of how or why binge eating is a coping response for a negative mood and, thus, what contributes to the maintenance of binge eating – the function it serves.

Binges as addictive

In Theme One, the sub-theme ‘history of food control’ identified participants’ childhood experiences of having their food intake monitored and controlled, as well as broader experiences of feeling controlled in their lives. The sub-theme examined here, ‘binges as addictive’, examines the extent to which participants as adults do and do not feel ‘in control’ of their bingeing behaviour as well as the extent to which they explain their BED by labelling themselves as ‘addicted’ to food or bingeing and how this labelling may or may not function to perpetuate bingeing behaviour.

In talking about their experiences of bingeing participants very often talked about their sense that they did not feel ‘in control’ around food or during bingeing. ‘Lack of control’ is a defining diagnostic characteristic of both addiction and BED in the DSM-V (APA, 2013). Further, issues of control are thought to play a pivotal role in both the development and maintenance of eating disorders (Froreich, Vartanian, Zawadzki, Grisham & Touyz, 2017). It has been suggested that it is a core experience of lack of control which leads individuals to engage in disordered (‘out-of-control’) eating as a way of regaining a sense of control (Froreich, Vartanian, Grisham & Touyz, 2016). The paradox of this ‘solution’ was certainly expressed by the participants of the current study – bingeing understood as a ‘rebellion’ to exert a sense of personal control also being associated with a sense of being out of control during the binge. As a maintaining factor for binge eating, the study findings thus suggest the importance of considering an ongoing internal battle to establish a sense of being in control.

All of the participants in the study described loss of control, but they also talked about secretive behaviour, preoccupation with food and consuming food in order to regulate affect, all of which are also reported by individuals with drug and alcohol dependence in relation to drugs and alcohol (Wilson, 1993). Further, some participants directly drew parallels between their binge eating behaviour and addiction behaviour, suggesting that they may experience binge eating in the same way as other addictive behaviours. The idea that bingeing behaviour is akin to addictive behaviour is expressed in the literature. For example, it is claimed that binge eaters share similarities with individuals who have addictive disorders (Cassin & von Ranson, 2007). More critically there is an emerging strand of research exploring the construct of “food addiction” (Finlayson, 2017; Long, et al., 2015; Meule, 2015; Ziauddeen & Fletcher, 2013). As an example, the Yale Food Addiction Scale (Gearhardt, Corbin & Brownell, 2009), which is the most frequently used instrument for ‘diagnosing’ food addiction, is built on the premise that ‘food addiction’ is mainly a biological construct and the instrument developers utilised substance use disorder criteria to develop the scale. A systematic and meta-analytic review of studies using the scale with almost 200,000 participants found 19.9% of the mainly female and mainly overweight or ‘obese’ participants met criteria for food addiction (Pursey, Stanwell, Gearhardt, Collins and Burrows, 2014). One study also found that 50% of people (e.g. not all) who meet the diagnosis for BED also meet the criteria for food addiction (Gearhardt, White, Masheb, Morgan & Crosby, 2012).

BED is conceptualised as an eating disorder with resulting attention in the literature typically paid to the psychological processes and individual factors that are potential causal factors; the idea that addictive food is also a factor in BED is quite a different understanding but it is one which seems to be in line with the experiences of at least some of the women in the study. Nonetheless the construct of addiction in the context of BED is not uncontroversial. Proponents (e.g. Cassin & von Ranson, 2007) for example point to the negative affect, guilt and shame that arises in both individuals

with addiction disorders and those eating disorders including BED (Gold, Frost-Pineda & Jacobs, 2003), and which were also reported by the women in the present study. Yet the addiction model of BED has been dismissed as reductive with the claim that “*only superficial similarities exist between binge eating and substance abuse*” (Fairburn, 1995, p.108). Similarly, the notion of food addiction continues also to be debated (e.g. Corsica & Pelchat, 2010).

One issue with the notion of food addiction in the context of BED is that treatments for addiction are principally concerned with supporting the ‘addict’ to progressively and permanently withdraw the addictive substance from their lives, something that obviously cannot be done with food (Gearhardt et al., 2012), despite the stated wishes of some of the women in this study. Despite this, and despite a lack of evidence supporting their efficacy, addictions-based treatments have been frequently used with individuals with eating disorders (Cassin & von Ranson, 2007; von Ranson, Wallace, & Stevenson, 2013) and have been recommend specifically for BED (Curtis & Davis, 2014).

Interestingly the ambivalence in the literature was also evident in the narratives of the participants of this study. Some clearly identified themselves as addicted and this understanding seemed to engender a fatalistic sense that the (addictive) relationship with food could not be changed. Other participants rejected the idea of themselves as addicted while a third group appeared ambivalent about the idea. Potentially framing binge eating as an ‘addiction’ lessens stigma for those who binge eat because it suggests that they are not to ‘blame’ for their binge eating because they are not in control/addicted. However, addiction also carries stigma (Matthews, Dwyer & Snoek, 2017), which suggests that the ‘addict’ label is a double-edged one for women who binge eat. In line with this, it has been suggested that using the word ‘addiction’ as a label for binge eating is potentially harmful as it can lead to adverse consequences such as the internalisation of the ‘addict’ stereotype and the adoption of an ‘addict’ mind set (Corrigan, Kuwabara &

O'Shaughnessy, 2009; Hebebrand et al., 2014; Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999).

In line with the idea that 'addiction' can be an uncomfortable understanding of binge eating behaviour for those who binge, a recent qualitative study involving people who met criteria for 'food addiction' (Cullen et al., 2017) found participants similarly varied in the extent to which they wished to label themselves as addicted, with some who were reluctant citing fear over being stigmatised by the label. Participants also expressed, like participants in this study, contradictory statements about whether they were, or were not, in control of their eating behaviour.

In summary, the existing literature around BED, eating disorders more broadly as well as food addiction, provides some support for the understanding by some women in this study that they are addicted to certain foods/bingeing and that thus this 'addiction' maintains their bingeing behaviour. However, acceptance of this understanding varied, with some women being clearly ambivalent. In the same way, the existing literature suggests a lack of current agreement around the notion of food addiction and the role of food/eating addiction in BED in particular, as well as some concern around the potential problems that may result if this understanding is uncritically accepted for example in terms of additional stigma for those who are labelled as addicted to binges. This creates some uncertainty about the idea that addiction to food/bingeing is a maintenance factor for BED.

Conclusion

The themes have been discussed in the context of the existing research. Broadly there is some support in the literature for a key idea in this thesis, namely that in order to understand the experience and function of bingeing it is important to consider explanations at three levels – interpersonal, relational and social. This conclusion accords with a speculative model proposed for understanding the function of binge eating in bulimic behaviour (McManus & Waller, 1995) which proposes that for any individual what matters is the

interplay of predisposing factors and specific triggers and how these factors operate at individual, familial and sociocultural levels. The notion of a 3-level explanatory model is significant since typically research on BED concentrates on one or at the most two levels.

A second key idea in the analysis is that the women were able to offer only partial, superficial and ultimately unsatisfactory (even to themselves) understandings of why they binge eat. Potentially this is because the participants predominantly seem to understand and experience binge eating as an individual deficiency rather than at the relational or societal level. Relatedly, the discussion has drawn on literature that suggests a lack of emotional awareness (alexithymia) may be present for those who binge eat, with the bingeing behaviour functioning to regulate emotion but also to potentially perpetuate non-exploration of deeper questions, such as what might be, for that individual, the root causes of their distress. Both these key ideas have importance for considerations of theory, research and treatment for women who binge eat and these will be discussed below.

Chapter 6: Implications and Findings

Implications for theory

The analysis and findings from the current study have a number of implications for the literature relating to eating disorders, BED, 'obesity' and related fields. First, while the study showed some support for the models at the level of individual psychology (e.g. restraint theory, escape theory, the affect regulation model, the emotion regulation model and addiction theory) overall the models seem to be too narrow of an explanation for binge eating. Although these are the most common and developed models used to explain BED the findings suggest they are lacking. Arguably the models are incomplete – for example, as previously highlighted, the findings of the study suggest the need for theory around positive emotional triggers and opportunity triggers which are little explored in the current literature. The results of this study also suggest that some models have variable acceptability for people who binge eat; participants were varied about their acceptance of an addiction model for binge eating. However most tellingly, models at the psychological or intrapersonal level of explanation fail to consider explanations that are relational and/or sociocultural influences which is problematic.

Second, the study findings are broadly in accordance with psychodynamic theory of BED which provides a useful relational model of explanation for binge eating. In line with the psychodynamic model, the findings suggested distal influences and, in particular, an unhealthy relationship with food and eating in childhood can influence the development of binge eating. A core important idea proposed by psychodynamic theorists and generally missing from contemporary research on BED is that the here and now need to binge eat is a response to a need to satiate a deep emotional craving which derives from relational deficits in childhood with parents. Arguably treatment which focuses only on improving the capacity to manage transient negative emotion without considering the deeper (relational/historical) wells of such emotion is going to be less successful.

Thirdly, the findings of this research support the idea that societal factors are important in explaining BED; this is an understanding that is largely missing from the current literature on BED. Further the study results suggest the value in combining the different levels of explanation to develop a more holistic model of BED, something that is largely missing from the current literature, which tends to be dominated by a medical and individualising focus.

A final theoretical consideration concerns the diagnostic criteria for BED. As previously mentioned, the current study took a pragmatic stance on using the diagnostic term 'binge eating disorder' with the main goal of both allowing the research findings to be considered in terms of the current literature (which is predominantly framed in terms of diagnosis) and to enable reaching and impacting a broader audience. A DSM-5 BED screening instrument was used to screen participants into the study and perhaps as a result as a group the participants in this study seem to experience and make sense of their binge eating in similar ways to the DSM – 5 diagnostic criteria. Nonetheless, the study findings also clearly demonstrate that the DSM-5 criteria provide a very limited understanding of the phenomenon of bingeing as compared to that provided by the study participants. As such, the study effectively demonstrated the reductive nature of diagnostic categories (Larrison, Brooks & Loewenthal, 2012).

Implications for therapeutic practice

The findings of this study have important implications for Counselling Psychology and other related disciplines working in eating disorders, 'obesity' and related fields. As previously discussed, overall, there is a broad convergence between many of the findings of this study and the extant literature on binge eating. However, although there are similar themes across the participants, the data also suggests consideration must still be given to the complexity of the phenomena, and to the individual experience, when considering how to facilitate therapeutic change. This said some key implications emerge.

One of the findings is binge eating seems to be a response to negative affect and lack of awareness and regulation of emotions. Given this, it is critical that interventions should focus on identification and awareness of negative affect and emotions and the development of better coping strategies. Relatedly individuals with BED may need to be encouraged to think about the deep/historical factors that might be contributing to their stress, which implicates a more holistic treatment approach rather than one just focused on promoting different (non-food) ways of coping with stress or where the treatment goals are simply weight loss or stopping bingeing.

Currently treatments developed to help patients with BN are often used with this population (Burton & Abbott, 2017) but the findings of this study suggests this may be unhelpful because the binge episodes are experienced differently. This study suggests bingeing during BED is used to alleviate negative affect and that alleviation is achieved once the food has been consumed. Bingeing in BN is also used to alleviate negative affect however this is achieved once the consumed food has been purged (Witt & Lowe, 2014; Cooper, 1988; Tachi et al., 2001). In order to facilitate individuals to change their behaviour this is potentially an important distinction and one that suggests it is important to explore for each client their individual sense of what they gain from bingeing to foster awareness of the role of binges in giving pleasure or in alleviating negative feelings.

The findings that a history of food control may be implicated in the development of BED suggests that individuals, with a significant role in the development and raising of children (e.g. teachers) receive education and training for the prevention of binge eating (Gubbels, Gerards & Kremers, 2015). This education should focus on praising and promoting qualities in girls other than physical appearance and conformity to adult expectations as well as identifying the signs that a child may be using food to regulate their emotions. Furthermore, Matton, Goosens, Braet and Van Durme's (2013) research also concluded that putting children on diets and singling them out as being 'too'

heavy/requiring food restriction is detrimental to their attitudes toward food and instead the focus should be placed on increasing activity.

Relatedly, the findings suggest the importance of exploring with the client how they make sense of their issues around 'control' in the context of bingeing. If for some individuals with BED, bingeing functions as a way of asserting personal control, it is potentially critical to collaboratively explore with clients, since while issues around power and control may always play a role in therapy, it may be particularly important for these clients. Further, some therapeutic approaches – e.g. psychodynamic – may be particularly useful in dynamically engaging with how issues around power play out in the therapeutic dyad in work with BED clients. For individuals who make sense of their bingeing in terms of an addiction model, it would also make sense to explore what this understanding implies for them – and the extent to which it both is and is not useful.

The evidence of social factors for this population also has significant relevance for treatment. Referring back to the previously made point regarding the fact that BED sufferers belong to two stigmatised groups, this could mean that they are more sensitive to the way that therapists refer to them and the language used by these healthcare professionals when discussing the disorder and the individual. For example, there is evidence that words to describe weight/body shape need to be carefully considered (Lydecker et al., 2016); potentially practitioners should ask clients what terms they themselves use or prefer to describe their own body/weight in order to avoid client feeling stigmatised by the therapist. As another example, when referring to 'loss of control', one of the key components of a BED diagnosis, practitioners should potentially be careful as this term possesses negative connotations associated with lack of willpower and self-control and may increase the level of judgement felt by the individual (Roberto et al., 2016).

Another consideration is the extent to which practitioners might want to explicitly draw on theory and research around weight stigma and to attempt to engage therapeutically in a way that helps clients to challenge societal

understandings around weight, in particular for women. This point is further discussed below.

Recommendations for Counselling Psychology

Besides implications for theory and practice, the findings of the study have implications for counselling psychology as a profession. One of the key findings was that societal factors – specifically weight stigma – has a role in BED. Research suggests, rightly, that psychological interventions for BED should take into consideration the weight stigma people have experienced (O'Brien et al., 2016). Given the significance of weight stigma, psychologists also need to consider that clients “may avoid the topic of weight in session, even when it may be a relevant and important issue to explore” (Akoury, Schafer & Warren, 2019, p. 17). Further, Brown-Bowers, Ward and Cormier (2017) call for psychologists to stop offering tools for weight loss, dieting and changing body shape but to suggest tools for resisting shame and oppression and “open up possibilities for the different ways that fatness may be accepted and explored” (p. 34).

However, as counselling psychologists we would be doing a disservice to not only to victims of weight bias stigma (and all other areas of stigma) but to our profession if we only sought only to alter interventions in consideration of weight stigma. Rather, as profession we need to do more with the goal of eliminating weight bias. In line with this, the BPS Division of Counselling Psychology Professional Practice Guidelines calls for Counselling Psychologists to “*challenge the views of people who pathologise on the basis of such aspects as sexual orientation, disability, class origin or racial identity and religious and spiritual views*” (p7). While these guidelines do not specifically mention potential bias when working with people of size, clearly, they should, especially given counselling psychology’s stance on social justice (Nutter et al., 2016). Equally it can be argued that counselling psychology should give thought to adopting and integrating some the tenants of the Health at Every Size (HAES) model (Bacon, 2010). The HAES model focuses on respect and acceptance of all body sizes and promotes a more holistic approach to health

and wellbeing, rather than a focus on weight loss (Penny and Kirk, 2015). Not only is the HAES more in line with counselling psychology, research shows, HAES based weight loss interventions show more psychological improvements in quality of life, body dissatisfaction and binge eating (Gagnon-Girouard et al., 2010).

An additional implication for the profession is the need for reflexivity over one's stance around weight. Unfortunately, psychologists are not immune from the cultural bias against fat people which may negatively affect a variety of clinical factors and most importantly the therapeutic relationship (Davis-Coelho, Waltz and Davis-Coelho, 2000; Puhl et al., 2013). Counselling psychologists and any other people working with "obese" individuals are encouraged to conduct an honest self-assessment of their biases against 'fat'. Even the best intended therapist who feels they can work with a client in an unbiased way but is not aware of their own biases jeopardises the therapeutic relationship. Besides anti-fat bias being experienced in explicit ways, microaggressions – intentional or unintentional slights or insults that communicate negative messages to a marginalized group member (Sue, 2010) - are often experienced in the form of weight bias in the therapy rooms (Schafer, 2014). Schafer's (2014) qualitative study found the most common microaggressions experienced by clients of size was therapists attributing weight as the cause of their presenting issue and recommending weight loss as a solution.

In conclusion, there are many ways counselling psychology can, as a profession, help facilitate awareness and change on weight stigma (see Kinavey & Cool, 2019) but one of the first steps, potentially, should be to incorporate this topic into the diversity training curriculum on counselling psychology training programmes. Ideally, the curriculum should also promote awareness and prevention of fat bias with an emphasis on combating the belief that 'fat' is controllable and educating trainees as to the significant impact fat bias and stigma has on the individual (Brown & Flint, 2013). Usefully, Bergen and Mollen (2019) provide very comprehensive suggestions and strategies for

the integration of size into multicultural education, training and practice for psychologists.

Revisiting Reflexivity

As part of a critical reflection on this piece of work, it is apposite at this point to revisit reflexivity, to consider the potential impact of the researcher's history and understandings on the findings and argued implications of this project. The earlier section on reflexivity outlined how my stance on the subject of this thesis shifted as I engaged with the project. Before I started the project, I had not engaged with the fat studies literature and it is significant that I did so as a result of trying to understand the participant's descriptions of their experiences of feeling judged in social settings for their weight, size and eating behaviours. Becoming more consciously aware of the academic literature on the societal influences (judgements) on women in terms of weight, size and eating has had significant implications for both how I hear my participants' stories and how I listen to my own self-talk on these topics. It has also fostered a passionate belief to use the study findings to challenge weight stigma by fostering greater understanding of the inter-relationships between binge eating disorders (and other eating disorders) and what has been described as "one of the last socially acceptable forms of discrimination" (Puhl & Brownell, 2002). This much clearer awareness of the importance of gender-based weight stigma has necessarily impacted how I have interpreted the data but in that this awareness has grown through the project analysis, I would argue that it evolved from the data rather than being foisted upon it.

A second and more personal reflection is that I did not initially anticipate all the ways the data might resonate with me. Over time, as I began to better "understand" the data and began to develop themes and sub-themes, I noticed my own relationship with it developing. Coinciding with this growing relationship with the data was an increasing awareness of my own past experiences and beliefs around food and eating and a realization of having experienced some of the very same issues which my participants described during the interview process. It is impossible to think this did not

influence the analysis, the emergent themes, how I chose to present the data and chose to consider it in the discussion. My sense is that this self-awareness of how my past experiences and beliefs potentially impacted the data analysis by allowing for a level of empathy for my participants and people with issues binge eating to develop. As a result, I feel the resulting analysis is stronger, deeper and richer.

Limitations

Limitations of this study and the transferability of results must be considered. A possible limitation to the study was the criteria used for participant inclusion. Past or current weight or history of weight loss surgery was not used to screen participants for inclusion in the study. This was done because research shows binge eaters can be both 'normal' weight and 'obese'. In addition, it is common for people presenting for weight loss surgery to have a history of binge eating (Mitchell et al., 2015). Nonetheless, it is possible that participants not concerned about their weight/without a history of considering or engaging in weight loss surgery would have given different accounts.

Relatedly, the recruitment process – referral through the participating hospital - used in the study presents potential limitations. The referral pathway may suggest that participants were less critical about the terminology of 'obesity' and the understandings of (excess) weight implied by this medicalised term. In addition, the fact that the interviews took place in the weight loss service in the hospital, may have influenced the participants' expectations and influenced the data – for example, potentially participants were prompted by the setting to talk about their bingeing behaviour in negative ways and to focus on 'needing to stop bingeing' as a prominent concern. For this reason, interviews in a different (more neutral?) setting might have elicited different narratives. In order to maintain participant confidentiality, the reason (s) why the participants made contact with the weight loss service is also not known and was not considered for inclusion criteria. Potentially self-referral versus other-referral (e.g. by family) may have

a big impact on understandings of binge eating as expressed in the interviews. Also, it is possible the staff at the weight loss service introduced bias during the screening process and when recommending who they felt was suitable for inclusion in the study.

The study population was also deliberately limited to only women. Although women present with more eating disorders (Button, Aldridge & Palmer, 2008), binge eating is more common in men than other eating disorders (less gender imbalance) (APA, 2013; Kessler et al., 2013). Further, the current literature suggests there are no significant differences in BMI and frequency of binge eating between men and women (Lydecker & Grilo, 2016). However, the literature does suggest women have significantly higher levels of weight, shape, and eating concerns than men (Grilo & Masheb, 2001; 2005) and that they disproportionately experience weight stigma. Hence the decision was made in the current study to include only women. Importantly though another potential limitation to the study was the lack of ethnic and socio-economic status as all the participants were white. Had the participant population been more diverse this too may have resulted in different data as it is known that attitudes towards and experience of body weight/size can vary by community, with more example more acceptance in some lesbian and African American groups towards bigger bodies (e.g. Heffernan, 1999; Latner, Stunkard & Wilson, 2005).

It should also be noted that the fact that these women were willing to participate in the study says something about them, since binge eating is typically a secretive and shameful activity (Citrome, 2015). The resulting themes may have been different for the respondent group compared to the non-respondent group, especially around shame and social stigma, as people who chose not to participate in studies tend to have higher levels of eating psychopathology (Dingemans et al., 2002).

As is the case with all qualitative research it is acknowledged that the findings result from the subjective interpretation of both the participant and the researcher (double hermeneutics). Another researcher would not only

have different interview transcripts (as the dynamics of the interview would have been completely different), another researcher might have interpreted the data differently and arrived at different themes

Despite these limitations, the findings seem to support existing literature, demonstrating a level of theoretical transferability (Smith & Osborn, 2007). In addition, as discussed in the methodology, steps were taken to ensure the quality and validity of the analysis, in line with recommendations of Smith et al., (2009). It is hoped this study might inform future research.

Future Research

The current study helped illuminate the lived experiences and sense making of women about their binge eating behaviour. Although the extant current literature on binge eating is growing, it is still very limited and qualitative research on binge eating is extremely rare. As a result, there remains much to learn and further qualitative research with those who meet criteria for BED is encouraged. In particular, given that the vast majority of the knowledge and understanding of BED comes from a positivist, quantitative paradigm, and is mainly derived from the literature on BN, research from a qualitative paradigm looking specially at BED is needed and welcome. Relatedly, given the comments made about the particularity of the sample in the current study, it would be useful to engage in qualitative work with different samples, e.g. men, 'normal' weight individuals with BED and those from a broader cultural background (non-British).

A commonly accepted premise is that knowledge gained through research is shaped by the epistemological and political positioning of the research(er) (Smith et al., 2009). In the context of BED there is a wide divergence between the research that accepts both the validity of a medicalised stance on 'obesity'/overweight and the value of a BED diagnosis, and research stemming from feminist/fat studies perspectives. Given this, as suggested by this study, studies coming from a more critical qualitative stance

should be encouraged. Critical qualitative research does not take the data at face value but looks beyond the meanings and experiences expressed in the data and explores how other factors, usually sociocultural, influence the reality constructed by an individual (Braun and Clarke, 2013). It would be useful for future research to examine experiences of individuals who binge eat from such an alternative approach to explore whether similar patterns emerge around the sociocultural factors that potentiate and maintain BED and which influence how women who binge eat understand their behaviour.

Methodologically, the field could also benefit from *quantitative* studies which are built from the results of qualitative studies exploring binge eating. For example, it would be useful to explore whether the factors identified in this research are also endorsed by a broader sample of individuals who binge eat. Relatedly, quantitative studies based on BED samples only are recommended because much of the current literature base, including treatment recommendations, on binge eating is taken from studies where binge eating occurs in various contexts (e.g. BN and BED samples combined). Arguably the mixed populations in much current research on binge eating obscures the role of bingeing in BED since the function and process likely varies between BED and BN.

In the current study, there were also several findings which warrant further investigation. First, triggers for binge eating do not seem to be purely negative. Exploring how positive emotions might trigger and influence binge eating is thus an area which might potentiate new understandings of binge eating and challenge the current, dominant theories framing binges as a result of purely negative affect and emotions. In addition, research exploring the 'pleasures of the binge' which were discussed in theme two, is also a potential area for future research. The current study found that most of the participants experience various positive experience during the binge episode and a better understanding how these positive experiences impact the functionality and maintenance of binge eating is needed.

Research looking specifically at moment-to-moment experience of affect across the binge episode in more depth might be a further area of interest. No studies in the literature, qualitative or quantitative, were found specifically researching the experience of binge episode (before, during and after). A study could use prompted mood recording with a qualitative mood diary or use of a standardised (quantitative) mood questionnaire to capture how mood shifts across a binge. In addition, such research might contribute to a better understanding of causal and maintenance factors in binge eating, which has important clinical implications in terms of both prevention and treatment development.

A final suggestion is that the field could also benefit from research looking specifically at the binge episode, from beginning to end, in more depth might be a further area of interest. No studies in the literature, qualitative or quantitative, were found specifically researching the experience of binge episode (before, during and after). A qualitative study of this nature might lead to a better understanding of the experiences and functions of the binge. In addition, such research might contribute to a better understanding of causal and maintenance of binge eating, which has important clinical implications in terms of both prevention and treatment development.

Conclusion

Although there is a growing literature base specifically looking at BED, it has been mostly quantitative, conducted from a positivist epistemology largely unquestioning of medicalised understandings of human experience and of diagnosis, and based off populations with a diagnosis of BN, thus ignoring the experiences and personal meaning of binges for those with BED. This research suggests that in order to holistically understand the experience and function of bingeing, it is important to consider explanations at three levels – interpersonal, relational and social. There has been relatively little attention paid to the impact of societal factors such as weight stigma on BED so this study has made an important contribution by providing an analysis of how contemporary social and cultural contexts potentially influence

individuals' engagement in bingeing. The study also demonstrated the potential importance of a history of food control, and of familial history in terms of eating, food and weight, in BED, which suggests the importance of exploring this topic not just with children and adolescents but also with adults with BED. The analysis also suggested that while the women were able to talk easily about proximal individual triggers for their binges that they were able to offer only partial, superficial and ultimately unsatisfactory understandings of why they binge eat. Potentially this is because the participants predominantly seem to understand and experience binge eating as an individual deficiency rather than at the relational or societal level. In other words, a more holistic understanding may be important to foster in clients with BED as well as in theories of BED.

The results of this study also suggest that in BED bingeing behaviour is maintained by the fact that it is a form of coping response to both negative affect and a history of food control; this is important because while the bingeing behaviour may provide temporary relief it also further promotes negative mood and a sense of being out of control around food. In this way, the 'triggers' for a binge episode become implicated as 'maintenance' factors in BED. Understanding this type of complex pattern in BED is key to help individuals break free from the behaviour.

In summary, this research has provided a new understanding of a largely unresearched area, that is how women with BED understand and experience their bingeing behaviour. In doing so it has both provided support for various theories of BED while suggesting that a more holistic understanding is needed.

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Appendices

Appendix A

Diagnostic Criteria: DSM-V – Binge Eating Disorder

1. Recurrent episodes of binge eating. An episode is characterized by both of the following:
 - a. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
 - b. The sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
2. Binge-eating episodes are associated with three (or more) of the following:
 - a. Eating much more rapidly than normal
 - b. Eating until feeling uncomfortably full
 - c. Eating large amounts of food when not feeling physically hungry
 - d. Eating alone because of being embarrassed by how much one is eating
 - e. Feeling disgusted with oneself, depressed, or very guilty after overeating
3. Marked distress regarding binge eating is present.
4. The binge eating occurs, on average:
 - a. at least 2 days a week for 6 months (DSM-IV frequency and duration criteria)
 - b. at least 1 day a week for 3 months (DSM-5 frequency and duration criteria)

5. The binge eating is not associated with the regular use of inappropriate compensatory behavior (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

Severity grading:

DSM-IV does not include a BED severity grading scale.

Applicable to DSM-5 only, BED severity is graded as follows:

- Mild: 1 to 3 episodes per week
- Moderate: 4 to 7 episodes per week
- Severe: 8 to 13 episodes per week
- Extreme: 14 or more episodes per week

* American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.



Appendix B

INFORMATION LEAFLET

Version 2 22/05/2010

Study Title

How women experience binge eating – An IPA study

You are being invited to take part in a research study (Title above). This information leaflet is designed to give you information about what the study involves in order to help you decide whether you would like to take part or not. Please read this carefully and write down any questions you might have or if you would like any more information. If you agree to take part I would be very grateful if you could contact me by email tracy.towner@uwe.ac.uk to arrange a time for a pre-screening telephone interview.

What is the research about?

The research aims to understand the lived experience of women who binge eat. Binge eating is one of the most common eating difficulties affecting approximately 2-4% of the population.

What would the research involve?

After a telephone conversation determining your appropriateness for the study, if you would like to take part you would meet with me two times in the mental health services premises in which you receive your treatment or support e.g. at a day centre or resource centre. The research will take place during normal working hours. In the first meeting we would talk more about the research and if you agree to take part, I would ask you to sign a consent form. We would then talk about when would be a good time to hold the interview (e.g. where, when, length of time). In the second meeting I would conduct the interview asking you questions about your experiences of binge eating. The interview would last about 1 – 1 ½ hours and will be tape recorded. I will also make notes while you are talking. Your comments would be combined with those of other interviewees to identify an understanding of binge eating. This understanding will be illustrated with extracts from the interviews. I may also need to contact you for a follow up telephone call or brief meeting to clarify the information you have provided and to ensure I reflect this accurately in my write up.

Who is organizing the study?

This study is being carried out as part of my Professional Doctorate in Counselling Psychology at the University of the West of England. I am being supervised by two of my University tutors, Dr Naomi Moller, and Dr Marianne Morris, contact details below. The research is not funded.

What are the possible benefits of taking part?

The experiences that you and other participants describe in your interviews will be shared with other professionals in the mental health community including psychologists, counsellors, doctors and other mental health professionals. It is hoped that the information from this project will aid in the development of treatments for people who suffer from binge eating disorder. If possible the study will be published in order to reach a wider audience. I hope that this will promote greater understanding of the experiences of individuals with binge eating disorder. Additionally, participating in this study might allow you to reflect on the personal significance of your experiences.

What are the possible disadvantages of taking part?

This research study is designed so that it will not cause you harm. However, some content of the interview might be difficult to talk about. I am aware that talking about your personal experiences of binge eating may be distressing and possibly bring back painful memories that may be difficult to manage. If at any time you would like to stop the interview or to stop the audio-taping, you can do so without giving a reason. Additionally, you will also be given information of agencies that provide assistance in the area of eating disorders.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential and will be locked in a secure place. All information that may enable people to recognize you will be removed from the write up. If you need to refer to individual professionals or other service users during your interview it is important that you do not refer to them by their real names so that I am not able to recognize them. Accounts will be anonymised by changing details such as names, dates and places. You will have the opportunity to choose a pseudonym for yourself for the purpose of the interview. If information is disclosed during the interview which indicates that there is a risk of harm coming to you then this will be reported to your care co-coordinator and or manager of the team you are under so that appropriate action can take place.

What will happen to the results of the research?

I hope to send the findings of the research to an academic journal for publication and you will be sent a copy of the results of this study if you would like one. I will also present the findings to others working in the mental health services. At no stage will your name be mentioned in any report or publication.

What will happen if the research stops?

If for any reason the research stops you will be informed and offered the chance to talk to me or my supervisor. Please see contact details below. All the material from your interviews will be stored in accordance with the Data Protection Act (1998).

Who has reviewed the study?

The study has been reviewed by the course team from the Professional Doctorate course in Counselling Psychology at the University of the West of England and the UWE Ethics Committee.

What do I do now?

If you would like to take part in the research please email me on tracy.towner@uwe.ac.uk to arrange a telephone interview. Please feel free to write down any questions you might have for discussion.

Thank you for reading this information leaflet and considering taking part in the research.

My contact details are:

Tracy Towner, Trainee Counselling Psychologist, University of the West of England, Faculty of Applied Sciences, Frenchay Campus, Bristol BS1 1QY

E-mail: Tracy.Towner@uwe.ac.uk

Phone No: 0117 3282175

You may contact me following the research should any stress, questions or concerns arise. You can also contact my supervisors from the University:-

Dr Naomi Moller (Research Director) or Dr Marianne Morris

University of the West of England

School of Psychology

Faculty of Applied Sciences

Frenchay Campus

Coldharbour Lane

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Tel: 0117 3282175/01173282198 E-mail – naomi.moller@uwe.ac.uk or Marianne.Morris@uwe.ac.uk



Appendix C

CONSENT FORM Version 3 22/05/2010

Title of Project *How women experience binge eating – An IPA study*

Name of Researcher TRACY TOWNER

Participant identification code

Please read the following statements and initial the boxes which apply to you. If you have been able to initial all the boxes please could you sign the statement at the bottom of the form. If you have any queries please do not hesitate to ask. You are reminded that if you decide not to take part there will be no negative consequences for you.

I have read and understood the information leaflet for this study and have had the opportunity to ask questions.

I understand that I do not have to take part and I can change my mind about being involved at any time, without giving reason.

I agree to have my interview tape recorded. I understand that following transcription, the tape will either be destroyed or returned to me.

I understand that extracts from my interview may be used in publications or presentations about this study but that I will not be identifiable from these.

Igive/do not give (please delete as applicable) consent to participate in this study.

Name of participant	Date	Signature
.....	
.....		

Name of person taking consent	Date	Signature
.....	
.....		

Appendix D

Interview Schedule Revision 3

1. **Tell me about your binge eating?**
 - **What has been your experience of binge eating?**
 - **How do you feel after the binge both physically and emotionally?**
 - **How does food play a role in how you feel or your mood?**
2. **Current relationship with binge eating?**
 - **How are you currently feeling about your binge eating**
 - **Can you describe times in the past when you felt more in control of your binge eating/out of control**
3. **What do you think drives your binge eating?**
 - **Have you had any mental health concerns**
 - **Do you feel that other mental health issues contribute to your binge eating? Or does binge eating contribute to other mental health issues**
4. **Dieting**
 - **Tell me about past diets or dieting you have tried**
5. **Body Image**
 - **How good do you feel about yourself**
 - **Has there ever felt good about your body? Can you describe them?**
 - **When do you feel less positive about yourself?**
 - **What factors influence how you feel about yourself?**
6. **Show BED criteria. How do you feel about the diagnosis of BED?**
 - **Positives/Negatives**
7. **Is there anything else you would like to add?**

Appendix E

Theme development

	Alice	Betty	Claire	Donna	Eve	Fran
Experiences of Binge Eating						
Looking Back						
Parents/Family	X		X		X	X
Negative Self concept	X	X	X	X		X
Bullied	X		X			
Escaping from a void I need to Fill						
Escaping from feelings	X	X	X	X	X	X
Coping Mechanism	X	X	X	X	X	X
Fulfilment of emptiness	X		X		X	X
Do I control it or Does it Control Me?						
Addiction		X	X	X	X	X
Control/Out of Control	X	X	X	X	X	X
Dieting	X	X	X	X	X	X

Appendix F

Further theme development

Superordinate themes	Subthemes	
Why do I binge eat? <ul style="list-style-type: none">• key idea lack of insight into triggers	Proximal triggers <ul style="list-style-type: none">IndividualFamily/friends influenceRelationalSocietySocial	Negative Affect <ul style="list-style-type: none">Emotions – positive?ControlNegative self-conceptStigmaJudgmental
Why do I keep doing this?	Positives – what do I get from this? Function	Pleasure, calming, disassociation/enjoyable
Maintaining and perpetuating factors <ul style="list-style-type: none">• key idea binge process is dissociative and that is the positive• Lack of insight – process repeats	Individual <ul style="list-style-type: none">Addiction/controlRelational/societal I just can't stop!	Need for control <ul style="list-style-type: none">Framing as addiction – makes it ok

Appendix G

Extract of a coded transcript

(Claire's transcript, lines 393-415)

Transcript	Codes
<p>Umm (pause) so I suppose that's how I would define a binge eat, er a binge eating session. Umm and I...I would, I see it more as comfort eating umm and as far as I'm aware, it...it isn't linked to anything in particular that's going on in my life apart from perhaps boredom umm sort of feeling of stagnation. But it's not, it's not attached to any feelings that have happened during the day.</p>	<p>Names binge eating as comfort eating.</p> <p>Contradicts self by claiming there is no trigger but yet then sees it connected to boredom and stagnation. Not connected to day to day issues.</p> <p>Claims no specific triggers</p> <p>Not attached to feelings/emotion?</p>
<p>Tracy: H-hmm.</p>	
<p>Claire: Umm so there you go. That's what, how I see it.</p>	
<p>Tracy: You mentioned zoning out and going away...</p>	
<p>Claire: (crosstalk)Yes.</p>	
<p>Tracy: ...can you tell me more about those experiences and those feelings associated with that?</p>	
<p>399. Claire: I can, yes. Umm for me that, that...that is...that is as a result of a binge. I don't do it because of that as...as far as I know umm. It's...it's the result of...of the binge. It's as a result of having everything in place to have the binge umm and it's a feeling of (short pause) umm calm and sort of fulfilment I would say. And umm (pause) pleasure I suppose umm not sort of wanting it to end umm (pause) although I...I'm, I...I've, I...I'm fully aware that it does come to an end and that's...that's perhaps why bingeing came to its sort of height before I had the operation because I was, it was...it was increasing in size, the actual binge. I would have a</p>	<p>Denies bingeing to zone out.</p> <p>Is this a form of control? The planning having everything in place?</p> <p>Bingeing provides fulfillment</p> <p>Connects the experience of bingeing with pleasure. Bingeing as an activity that brings pleasure?</p>

lot more umm altogether in...in one go than I was, you know ten years ago or something.

Umm but those feelings umm (pause) those feelings I suppose w-...were (short pause) like I said they weren't as...as, as umm they weren't a trigger for me wanting to have a binge if that makes sense. They...they weren't something that I was looking for umm it was just as a result of it, as a result of wanting to feel full umm.

Tracy: Can you describe the feelings a bit more? Can you tell me more about?

Claire: Describe them more. Umm (short pause) I...I suppose, you know having...having taken drugs and stuff in the past I suppose it's...it's kind of similar to a high umm you just, you feel like your umm like floating away or you feel like you're umm escaping a reality in a way. Umm (short pause) it's almost sleepiness. It's almost as though your, you know and that...that state of mind that you have as you're going to sleep, it's that kind of in between being awake and being asleep.

Tracy: Okay.

Claire: Yep.

Tracy: You use the word routine with your binge.

Claire: Yep.

Tracy: Can you tell me what a routine, like help me try to understand what you, a bit how a binge would go from start to...to finish.

Claire: To finish. Umm well routine first of all for me it's...it's not so...so important now because I'm not able to do what I was then. But talking about before I had the band a routine for me was incredibly important if I wanted a binge. And everything had to be in...in,

Denies again that feelings are not associated with bingeing.

Denies again any trigger.

Claims that bingeing is associated with feeling 'full'. What void is she really trying to fill? Lack of pleasure, lack of satisfaction?

Compares feeling to drug taking? Seeing bingeing as similar to drug taking?

Describes floating, escaping, not being fully aware of things.

Stresses the importance of planning, routine. Is this a need for control?

Planning/anticipating

Tracy: (pause) So what, can you tell me about like what you thinking as you were going down to the shops?

Claire: It's a feeling of looking forward to it or (short pause) ah I don't, that's not quite true. It's....it was a feeling of (short pause) anticipation and sometimes that would be a sort of "Oh I'll have to do this again." Or like umm (pause) anticipation whether it's good or bad I would say that's what I was thinking just looking forward to completing it, the binge.

Tracy: Would you experience in umm anything different during the binge? Would these feelings change?

Claire: I see what you're saying umm (pause) umm that's...that's difficult to answer because...because I'm so far away in my head it...I never really, I never really think about it. I don't really know what I'm thinking during it because I'm, I just... I'm quite intent on doing what I'm doing.

Tracy: H-hmm.

Claire: Umm at the time. Umm (short pause) I suppose the anticipation isn't there because you're in the middle of doing it so you don't feel, you don't feel like you're anticipating something anymore because you're in the middle of...of completing the sort of cycle or the routine of having the b- umm the...the binge.

Contradiction here. Claims she experiences a feeling of anticipation but at the same time sees things as a chore/ also previously states – no triggers.

Seems to like binge eating

Frames as positive?

Wants to repeat.

Claims no connection or thought process during the binge?

Does she experience feelings?

Possible disassociation.

Very determined.

During this binge it is almost like she is describing an absence of any feelings or thought, again as disassociation? Almost as if she is void of thought process – 'void', 'empty'?? A robot going through the motions?