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## RESEARCH ARTICLE

# Individuals with restrictive eating disorders' experience of the introduction of calories on menus in England: An interpretative phenomenological analysis study

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## Abstract

**Objective:** In April 2022 the Calorie Labelling (Out of Home) Regulations came into effect in England where cafés, restaurants, and takeaways with over 250 employees were required to provide calorie labelling on menus. Concerns have been raised regarding the potential negative impact this could have on individuals with eating disorders (EDs), yet this has not been explored using qualitative methodology.

**Method:** Eleven participants with a current or previously diagnosed restrictive ED were interviewed in September 2022. Interpretative Phenomenological Analysis (IPA) was used to explore their experience of the introduction of calories on menus.

**Results:** Using IPA we established six themes and seven subordinate themes. These included the introduction of calories on menus as an 'attack' on individuals with EDs; the prominent visual display of calories as an attentional pull; normalising of calories counting; the impact on behaviour; and associated strategies for managing.

**Conclusion:** This contributes to research surrounding the implications for public health policies on individuals with EDs, especially their ability to reinforce and amplify disordered thoughts and behaviours, and the need for greater consideration of how to minimise impact and potential harm of large public health campaigns.

## KEYWORDS

eating disorders, overweight and obesity, public health

## Highlights

- Many of the participants believed that calorie counting played a pivotal role in their experience of an eating disorder (ED), and that the calorie labelling legislation normalised this via (1) its legitimisation in messages from the

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government and public health bodies, and (2) diet talk by dinner companions, prompted by the calories on menus.

- Participants described a broad range of impact that the legislation had on their ED cognitions, eating out choices, and compensatory behaviours as an amplification of pre-existing difficulties.
- Many participants stated that they had to conjure additional mental effort to overcome their thoughts and make food choices when eating out and had developed a range of coping strategies. Participants described very few positive experiences of using the optional calorie free menus proposed by policy makers.

## 1 | INTRODUCTION

Rising obesity rates have prompted a significant increase in public health activity focused on changing individual eating and exercising behaviours (Holmes, 2021). Within this policy context, there have been concerns raised around the potential harm of such ‘obesity strategies’ on those with, or at risk of developing, an eating disorder (ED) (Bristow et al., 2022; Hawking et al., 2023). One such example is the recent Calorie Labelling (Out of Home) Regulations (2021) that came into effect in England in April 2022, which aim to ‘empower’ individuals to make ‘healthier choices’ by ensuring consumers have access to clear information about calorie content of foods. In practice this means that all cafés, restaurants, and takeaways with over 250 employees are required to provide calorie labelling ‘clearly and prominently’ at the point of choice, alongside a statement that ‘adults need around 2000 kcal a day.’ Restaurants are allowed provide ‘calorie-free’ menus at the request of the consumer, although provision of these is not compulsory. This legislation has come under criticism from several different perspectives, including the limited high-quality research on its short- (Crockett et al., 2018) and long-term effectiveness (Petimar et al., 2019); whether calories are the most important nutritional information to focus on (Yeo, 2022); the omission of social determinants of health (Raffoul et al., 2022); and the potential harms of this legislation, including for individuals with EDs.

Concerns have been raised in the field of EDs around the introduction of this legislation due to cross-sectional and prospective research linking dieting, inclusive of calorie counting, to ED symptomatology (e.g. Stice et al., 2017). Furthermore, dietary restraint takes a central role in leading theoretical models of the development and maintenance of EDs (e.g. Dual Pathway Model [Stice, 1994, 2001]; Fairburn Transdiagnostic Model [Fairburn et al., 2003]). Parallel research on health tracking technology has identified a link between the use of calorie tracking applications and eating concern and dietary

restraint in students (Simpson & Mazzeo, 2017) and these applications are frequently used in clinical ED populations (Levinson et al., 2017). Therefore, the introduction of calories on menus may be potentially concerning for individuals vulnerable to ED symptomatology or those with living/lived experience of an ED. However, there is also evidence that individuals with Anorexia Nervosa significantly overestimate calorific intake of a meal (Sysko et al., 2005). Therefore, it has been hypothesised that some individuals with EDs may find calories on menus to be a tool to support more accurate representations of calorific intake (Roberto et al., 2013) and potentially facilitate out of home eating.

The research evidence on the impact of calories on menus on individuals with EDs is limited and there are mixed findings. One study has found no adverse effects in general population samples (Lillico et al., 2015) but others have identified potential negative impacts. For example, in a large population-based survey Larson et al. (2018) found that using calories on menus to limit intake was related to binge eating among women and with more weight related concerns, dieting and ‘unhealthy’ weight control behaviours (e.g., the use of laxatives) among both men and women. Furthermore, the use of menu labels to limit calorie intake was most frequent among participants using ‘unhealthy’ weight-control behaviours, compared with those using only ‘healthy’ behaviours (e.g., eating more fruit and vegetables) (Larson et al., 2018).

Controlled, experimental work has also suggested complex impact on those with disordered eating behaviours. For example, Haynos and Roberto (2017) conducted an experimental study with females with disordered eating using hypothetical calorie labelling scenarios. This study found that participants with Anorexia Nervosa or Bulimia Nervosa tended to order significantly *fewer* calories for a hypothetical meal with calorie labels; whereas participants with Binge Eating Disorder ordered significantly *more* calories (Haynos & Roberto, 2017). This is an important finding as it suggests

the legislation could be detrimental in different ways for differing types of EDs, a point which is often overlooked. Mixed findings in the small number of existing studies may in part be explained by differences in sampling, settings and methods used (Larson et al., 2018). There is therefore a need to extend the evidence base to gain a full understanding of the potential impact of these legislative changes.

To date there have been no published studies using qualitative methodology to explore the experiences of individuals with EDs when facing calories on menus. This is essential to investigate whether the concerns around potential risk of harm reflect the experiences of those living with EDs, especially taking into account the increased mortality, reduced quality of life and economic costs associated with EDs (van Hoeken & Hoek, 2020). This study aims to extend the limited evidence in this area by using qualitative methodology to explore the impact of the introduction of calories on menus via the Out of Home legislation in England on individuals with lived/living experience of an ED.

## 2 | METHODS

Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022) was chosen due to its emphasis on understanding the way individuals' experience phenomena and its ability to acknowledge the complexity of experiences. IPA is a qualitative approach which aims to provide an account of lived experience in its own terms rather than one prescribed by theoretical pre-conceptions. It also acknowledges the interpretative nature of analysis, where the researcher is trying to make sense of the participant's account. Finally, IPA has an idiographic focus, instead of focusing on generalisability of findings, it is committed to the detailed experience of each case in turn. The study received ethical approval from the University of Edinburgh (CLPS242, August 2022) and all participants provided written informed consent.

### 2.1 | Participants

Participants met inclusion criteria if they were over 18 years old, identified as having a current or previous ED, lived in England, and had experienced calories on menus following the legislation's introduction. Inclusion criteria were kept purposively broad. IPA is an idiographic approach, concerned with detailed understanding of an individual's experience of a particular phenomenon therefore uses small sample sizes (5–16 participants; Smith, 2011). Initially, individuals with a current ED and

those who identified as being in recovery were recruited as two separate groups. However, during analysis it became clear that these two groups had aligned experiences and met criteria of being one purposive homogenous group (Smith et al., 2022). A precedent has been set for the inclusion of individuals with both current and previous diagnoses of EDs in similar IPA research (Bristow et al., 2023) with the authors highlighting that recovery from EDs is non-linear with long-lasting effects (Bowlby et al., 2015; Steinhausen, 2009; Wetzler et al., 2020).

### 2.2 | Procedures

Study recruitment launched September 2022, five months following the implementation of the Out of Home legislation. Purposive sampling (Smith et al., 2022) was implemented to recruit individuals with lived experience of an ED via social media and associated snowballing. Participants completed an online survey collecting relevant demographic data and provided their email address to be contacted by researchers.

Participants were invited to attend an online interview hosted on Microsoft Teams. The interviews were guided by a series of questions (see Supporting Information S1) considering participants' awareness of the legislation, their experience of an ED and their experience with the new legislation. The interviews lasted between 27 and 57 min (average 42 min).

### 2.3 | Participant characteristics

The final sample ( $n = 11$ ) consisted of five individuals who identified as recovered from an ED (female  $n = 5$ , 100%; Mean age 31 years; SD: 8.77, range 19–45 years) and six individuals who identified as having a current ED (female  $n = 5$ , 83%; Mean age 34 years; SD: 6.42, range 27–41 years). Participants self-reported their ED diagnosis in the initial online survey collecting demographic data. All identified with restrictive EDs including Anorexia Nervosa, Atypical Anorexia and Other Specified Feeding or Eating Disorder (See Supporting Information S2). The recruitment of individuals who only identified with restrictive EDs was not intentional but reflected the group that responded to advertisements for the study.

### 2.4 | Analysis

Analysis was undertaken by two researchers (FD & IP), initially working independently before coming together

to work on the final themes, which were developed through iterative discussion in collaboration with a co-researcher with lived experience of a restrictive ED (EM). Microsoft Teams provided verbatim transcriptions which were then checked and anonymised. Researchers followed analysis as outlined by Smith et al. (2022). Transcripts were analysed case by case and each transcript was read multiple times to allow immersion. The transcript was arranged into a table with initial exploratory notes made in the right margin, followed by experiential statements in the left margin (See example in Supporting Information S3). This was repeated for each transcript before combining individual experiential statements to develop group experiential themes. Due to the initial recruitment of 'recovered' and 'current' groups, group experiential themes were initially developed separately by group. A clear recurrence of themes and convergence of data indicated one homogenous sample, leading to the merging of group experiential themes.

## 2.5 | Positionality statement

IPA emphasises the significance of the interpretation and influence of the researcher. Researchers involved in the interviews and analysis were a consultant clinical psychologist and an assistant psychologist, both working with individuals with EDs clinically and in research. Both were concerned about the impact of the legislation on individuals with a history of an ED. A co-researcher with lived experience consulted on the analysis.

## 3 | RESULTS

IPA established six themes, with seven subordinate themes. Participants are referred to by their identification with a current ED (C) or in recovery (R) and associated participant number to protect confidentiality, for example, C4. An overview of themes is presented in Table 1.

### 3.1 | Calories on menus as an attack

A consistent theme within all participant interviews was the perception that the legislation was a direct attack on those with EDs. Both participants that identified as experiencing an ED currently and those in recovery believed that the legislation was going to be damaging for those with lived and living experience of an ED.

TABLE 1 Overview of themes.

Superordinate themes	Subordinate themes
Calories on menus as an attack	Calories on menu as a perceived personal attack
	Calories on menus as ineffective and problematic
Calories in spotlight	
Normalising calorie counting	Legitimisation of the legislation
	Diet talk
Active management	
Impact on behaviour	Louder thoughts
	Food and eating out choices
	Eating behaviours
Strategies for managing	

#### 3.1.1 | Calories on menu as a perceived personal attack

Many of the participants were aware of a campaign by Beat, the national ED charity in the UK, which highlighted concerns about the use of calories on menus and the potential negative consequences for individuals with EDs. Heightened awareness of the pending implementation of the legislation was apparent with participants describing being aware of 'rumours' (C1) of the legislation coming to into effect and signing petitions to prevent implementation (C1, C3). Social media appeared to be a mechanism for most of this communication and accessing associated information, with C1 described 'scrolling' through the legislation when it was first published. A build-up of strong emotions was fuelled by a perception that the concerns of individuals with EDs were being ignored, or dismissed as not being as important as the government's need to provide interventions to reduce obesity. As a result, it was interpreted as a personal attack.

Someone like me has now like, had their kind of recovery attacked almost, which sounds quite dramatic but it was, I was like, and that led to me feeling really bad.

(C1)

Many participants appeared protective and described concerns about the impact the legislation would have on young children or those in the earlier stages of their EDs. Similarly, C3 was able to identify anxiety that it could

'trip' them up within the context of working hard towards recovery, inferring an obstacle being put in their way.

I never want to fall back into behaviours I've done, I'm always trying to move forward with in a sometimes not a positive way, but I'm always trying to move forward and not look backwards and I was worried it was going to trip me up backwards the kind of calories on menu stuff so yeah.

(C3)

### 3.1.2 | Calories on menus as ineffective and problematic

Participants' frustration appeared to be exacerbated as they perceived that the legislation was ineffectual and that a full risk assessment had not taken place on potential harm. Some participants were sympathetic to the aim of the legislation (R2, C1), whilst others were against the underpinning principles of obesity campaigns and debated the definition of health (R5). Regardless of perspective, almost all the participants were disturbed by the perceived lack of evidence to support the implementation of the legislation.

For example, C1 reflected on getting a coffee with their father, who they described as a 'prime candidate' for obesity campaigns. Their father was oblivious to the calories and made the same food choices as he would have prior to the legislation, whereas in contrast C1 panicked and struggled to manage their food choices.

So it just completely screamed at me that this legislation has done absolutely nothing for the person it's meant to affect.

(C1)

C1 was discouraged that she was subjected to unnecessary distress whilst there was no influence on her father's behaviour. Similarly, R1, a recovered participant, questioned why the legislation would be implemented if evidence of its effectiveness was not robust, and if it was potentially risky for those with an ED.

Yeah, it is kind of detrimental to people affected by EDs, then what's the point?

(R1)

The combination of perceived lack of evidence on the effectiveness of the legislation, alongside dismissing the potential impact it would have on individuals with EDs, created frustration among participants and a perception of the legislation as being an attack.

## 3.2 | Calories in spotlight

The legislation requires calories to be displayed 'prominently' at the point of customers making their food choices. All the participants described the visibly displayed calories as having an attentional pull and felt them to be 'unavoidable.' This led them to focus on the calories rather than the other components of a menu (C2, C3).

Like it's on the paper menu. It's on the full menu and there's, like, no escaping it. That sounds a bit drastic, but it's just in your face.

(R4)

It feels like it just spotlight goes to that. It's like I'm almost not even looking at what the item is.

(C2)

Some participants experienced the display of calories as a visual overload with the calorie information completely absorbing their attention. One participant described how their focus on the calories overwhelmed them to the extent that they were unable to consider food choices.

I felt like I picked up a table of numbers and I couldn't really see any words like it was just numbers screaming at me.

(C3)

Other participants voiced their frustration at unexpected elements of implementation, such as that calorie information were being presented on sauces, condiments, and drinks (R1, R5), which they had not felt prepared for.

## 3.3 | Normalising calorie counting

Many of the participants believed that calorie counting had played a pivotal role in the development and their ongoing experience of an ED (C1, C3, C4 etc). Participants felt that the legislation normalised calorie counting via (1) its legitimisation in messages from the government and public health bodies, and (2) diet talk by dinner companions prompted by the calories on menus.

### 3.3.1 | Legitimation of the legislation

Participants felt that the legislation mirrored and reinforced several of their ED beliefs and behaviours via providing the tools for calorie counting, promoting the

lowest calorie option, and equating health with low calories.

It just reinforces the thoughts that I have, like, I don't know, I don't need that because this is what it says here.

(C4)

I think having that externally reinforced that calorie counting is a thing that you should be doing.

(R4)

A crucial consideration for participants was the role the UK government and public health organisations had in legitimising the importance of calories, inferring everyone should be actively using this mechanism to support food choices and weight loss. The government and the NHS were seen as authorities on health, and this was interpreted therefore as something participants felt responsible to do.

They're doing this for my benefit, and they think I need to lose weight and almost taking it quite like a personal – they think, the government thinks I am too big, therefore, I need to lose weight.

(R1)

Participants were confused by the legislation directly contrasting with advice they had received in treatment. Many of the participants were being supported to actively move away from calorie counting in their recovery or take a critical account of the validity of calories as a measurement of nutritional need, yet the new legislation actively encouraged this.

I find it really confusing because in my mind I'm like I've had so much intensive treatment and I'm having all these people tell me that that that that is not the right thing for me to do. In terms of like counting calories and all of that.

(C1)

### 3.3.2 | Diet talk

Several participants (C3, C4, R3, R5) felt that there had been an increase in talk about calories when eating out with others, and that the calories on menus appeared to act as a prompt for their companions to actively discuss the need for compensation (after eating) and restriction.

I know people that I know that never cared about any of this stuff, you know, just ate what they wanted and ate fine. They weren't, you know, they just ate normally. And now they're starting to say oh, oh gosh, look at the calories on that, we'll have to do a workout tomorrow.

(R3)

R5, who identified as being in recovery from an ED, explained that hearing the diet talk led them to question what they had eaten and contemplate compensating or restricting as result. The diet talk of participants' peers served to legitimise calorie counting and compensatory behaviours as typical and normal.

## 3.4 | Active management

Many of the participants stated that, since the introduction of calories on menus, they were conscious of having to conjure additional mental effort to overcome their thoughts and make food choices when eating out.

Something that I'm really trying to work on is like pick what you want rather than what you think you should have. And when, that's already quite a difficult thing to do, but when you have the information of the calorie content there it makes it's like adding like an extra 5 steps.

(C5)

Participants reported this as being an additional burden that needed to be actively managed, meaning they were distracted from engaging with others or enjoying the social occasion.

It's made it so much harder by having the calorie information in front, because it just gives you this idea that it's what is important. And I just think it takes focus away from... food is about socializing and it's about going out, if you're going out for a meal, it's normally for a social, like a social occasion, erm and that's hard anyway. But then to add that dynamic to is just makes it feel impossible instead of hard.

(C1)

Whilst both those in recovery and those with a current ED had to actively manage their responses to

calories on menus, those in recovery identified frustration at feeling being drawn back to the need to use active coping techniques.

### 3.5 | Impact on behaviour

Participants described a broad range of impact that the legislation had on their ED cognitions, eating out choices, and compensatory behaviours. Participants indicated that the presentation of calories led to an amplification of existing difficulties. All descriptions appear to relate to short term increases in symptomatology, and it is unclear whether there were longer term implications on ED presentations.

#### 3.5.1 | Louder thoughts

Many participants felt more aware of their ED cognitions in the context of experiencing calories in menus and reported them as getting '*louder*'. C3 described how their ED thoughts quickly escalated, from calories into negative thoughts about themselves, resulting in them feeling overwhelmed.

I end up in this like cacophony of like sound in my head of numbers and which turns into like really nasty insults to myself... so it just escalates so quickly.

(C3)

Other participants experienced more pronounced ED cognitions but were able to actively manage them. This was dependent on their stage of recovery, with those who identified as recovered feeling that they were able to prevent those thoughts affecting behaviours.

It's [I'd] definitely say the thoughts are a lot louder than maybe just I found ways so that they don't translate into behaviours if that makes sense.

(R1)

#### 3.5.2 | Food and eating out choices

Calories being prominently displayed led to participants being drawn in to focusing on the caloric detail of different food items. For example, R1 noticed themselves falling into a pattern of '*sneaky behaviours*' in which they began to pit food choices against each other, which they

interpreted as slipping back into the ED. Instead of making choices based on personal preference, participants described finding themselves using calories on menus to choose the lower calorie option.

I would have chosen something that I actually would like, but I would have if I was choosing between two things. I would have chosen the one with less calories.

(R2)

There was this one wrap I loved but then the alternative wrap was a lot healthier, with higher protein and had less calories. So now actively choose that over the one I really used to like.

(R5)

When it came to decisions about where to eat, participants described being cautious about being heavily influenced by where had the most low-calorie options and instead would defer to others to make the decision or would actively choose smaller business which did not have an obligation to display calories.

If there are places where we know that there are calories on menus, we will probably avoid them.

(R3)

#### 3.5.3 | Eating behaviours

Calories on menus were identified as playing a role in amplifying ED cognitions and associated impulses to enact ED behaviours. There were different degrees to which participants engaged in ED behaviours. Some of the participants explained that they would carry the thoughts long after eating out leading to detailed plans of how to restrict or compensate.

I just knew the numbers and it affected what I did in the morning and it affected what like I did at night.

(C1)

Yeah, being sort of primed to think about the calories makes it almost easier for those like more disordered thoughts to be like, oh yeah, well, you need a lunchtime meal, but make it one with low calories.

(C2)



However, participants were more reluctant to make a direct connection between the legislation causing new ED symptomatology.

I did go for a run, which I was going to do anyway, but I was initially deciding whether I was going to run like 5K or 10K, and I went for 10K I think probably because of that. So yeah, I ran... I chose the higher distance of what I was going to run and miss breakfast. Yeah as a direct result of... And I never want to make it this black and white because I don't want to say just because the number was under menu that but ...but it was definitely a trigger point.

(C3)

### 3.6 | Strategies for managing

Across the stages of recovery, participants explained different strategies that they used when eating out. Some participants were able to 'park' (C6) or 'ignore' (R2) the calories on menus, and others attempted to reframe their thought processes.

Like to not think of a calorie as something that's going to make you fat or make you feel bad, but to think of it as something that's going to make you more energetic and more happy and more able to go out and do more things you can't do when you're unwell.

(R2)

Other participants would rely on supportive friends or family to physically cover the calories on the printed menu and order for them. In these instances, their friends or family would take on the responsibility and shield them from the calorie information.

When I've been out for meals, it'll be with people that [are] really close, like my best friend or my husband and like so they know already and so they help me prepare and will either print me off a menu or they'll take a sharpie with us and they'll just start scribbling on the menu for me so I don't even have to look at it.

(C3)

Participants would also lean on strategies they had developed in ED treatment. Some recovered participants expressed frustration that they were only able to do so

because of being in therapy for a prolonged period. This infers some concern for individuals who may not have had the opportunity to have developed such strategies.

I think I've found ways to manage it. And I think that is only because I've had what like, I had seven years of therapy and I've had seven years of building on that and finding the strategies.

(R1)

Optional menus without calorie information were identified as being potentially helpful in navigating eating out by policy makers. However, participants described very few positive experiences using them. Some participants were reliant on calorie free menus (C6, R3), and restricted their choice to restaurants where they were available, though they were often left waiting to receive them or were unavailable (C6, C1). Requesting a calorie free menu made many of the participants self-conscious (e.g., C2, C3, C5, R1, R4), with C2 explaining how it was 'exposing' to ask and perceived it as was 'inviting someone to make a judgement about why you're asking for the menu without calories' (C2).

## 4 | DISCUSSION

This qualitative study aimed to explore the impact of the introduction of the Calorie Labelling (Out of Home Sector) Regulations (2021) on individuals with lived experience of an ED. Using IPA, six themes were identified with associated subordinate themes.

A prominent theme was that the implementation was perceived to be a 'personal attack' on individuals with EDs. Participants felt that the concerns of individuals with EDs had been dismissed by policy makers, and expressed frustration that this was at the expense of an obesity strategy which was perceived to be ineffectual. The strength of emotion was significant and at odds with an absence of frustration for similar legislation such as mandatory nutritional declarations (EU Regulation No. 1169/2011) or the UK government recommendations of 'traffic light' colour coding of the front of pre-packaged foods in supermarkets (DOH, 2016). It may be important to place these findings in the context of a prominent campaign by a UK ED charity (Beat, 2021) which was communicated widely on social media and was referenced by multiple participants. Frustration appeared high as despite this campaign, the legislation was still implemented, and this occurred shortly after the COVID-19 pandemic where there were highly publicised increases in ED presentations internationally (Agostino et al., 2021;

Hyam et al., 2023; Springall et al., 2022). Interviews also took place only 6 months after the introduction of calories on menus, therefore individuals may still have been adjusting to the changes. It is feasible that experiences of calories on menus may change over time as these become increasingly established and commonplace, so it will be helpful to continue to explore the impact of this legislation following this immediate introductory period.

A further theme that was identified was 'normalising calorie counting,' where it was felt that the legislation promoted and normalised the use of calorie counting, an activity that played a significant role in participants' experience of an ED. These findings are aligned with previous research where public health obesity campaigns have been identified as providing justification for thoughts and feelings associated with an individual's ED (Bristow et al., 2023). The perceived increase in diet talk amongst peers while eating out is an interesting finding that warrants further investigation. The justification of the introduction of calories on menus has been to provide individuals with information to make an informed choice with regards to their personal food choices. The social impact of comments about weight, food and exercise have perhaps not been fully considered, and has important implications considering diet talk has been associated with body image dissatisfaction (Sharpe et al., 2013), a significant risk factor for disordered eating (Bucchianeri et al., 2016). These concerns mirror ongoing and larger discussions around unintended consequences of public health obesity strategies, notably the potential to cause harm by increasing risk of developing disordered eating (Cogan et al., 2007; Hawking et al., 2023) leading to calls for greater joint research and collaboration between the obesity and ED fields (Hay & Mitchison, 2019).

Participants described a range of ways that the legislation had impacted on their ED cognitions, eating out choices, and compensatory behaviours. This was experienced as an amplification of existing disordered eating experiences, rather than triggering new symptomatology. However, of concern was that this was experienced by both individuals with a current ED and those who identified as being in recovery, some of whom had been in recovery for many years. Recovered individuals described frustration that they were being drawn back to actively managing thought processes they had not experienced for a long period of time, in conjunction with annoyance of this interfering with the social and enjoyable occasion of eating out. While some individuals were able to identify coping strategies, the uptake of calorie-free menus, a solution proposed by policy makers to support those ED navigate this policy, was limited, and perceived to be exposing. There is clearly a need for clinical ED services to plan and consider how to support

individuals in managing calories on menus more actively. A challenge may be for clinicians to support individuals in navigating recovery within a sociocultural context and society that to some degree promotes weight consciousness and eating restraint (LaMarre & Rice, 2016).

A significant limitation of our study is the lack of diversity in ED representation and demographics of our sample. Epidemiological data indicates that individuals of all genders, sexual orientations, ages, ethnicities and socio-economic status suffer from a range of EDs (Qian et al., 2021). Yet there is a lack of diversity in both treatment settings and ED research (Halbeisen et al., 2022). It was hoped that open recruitment via social media, rather than clinical services, would increase the diversity of our sample however there is also evidence to suggest that media may reinforce stereotypes of EDs, increasing stigma (Baffsky, 2020). It may be that this associated stigma meant that certain groups were more uncertain about coming forward to share their experiences.

Finally, the nature of the IPA approach is that this research is an in-depth exploration of participants' experience of the phenomenon of the introduction of calories on menus. It does not aim to generalise findings beyond our sample. However, considering the lack of research in this area, an in-depth exploration of experience was felt to provide an essential baseline understanding to develop further lived experience informed research designs. Further research is required to investigate the experiences of calories on menus in individuals with non-restrictive EDs, especially considering previous research findings of potentially different associations with eating behaviours based on different ED presentations (Haynos & Roberto, 2017; Larson et al., 2018); the impact on children; and consideration of the policy for those in larger bodies within the context of weight bias.

To our knowledge, this is the first qualitative research to explore the experience of calories on menus on individuals with restrictive EDs. This contributes to research surrounding the implications for public health policies on individuals with EDs, especially their ability to reinforce and amplify ED thoughts and behaviours. This highlights the need for greater collaborations between these research and clinical fields and greater consideration of how to minimise impact and potential harm of large public health campaigns. Finally, it reinforces the need for collaboration between those with lived/living experience if an ED and clinicians to develop pragmatic advice on how to navigate a recovery process within a weight-centric society.

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## CONFLICT OF INTEREST STATEMENT

There are no conflicts of interests associated with this study.

## DATA AVAILABILITY STATEMENT

Data from participant interviews is not publicly available to protect anonymity.

## PATIENT CONSENT

Informed consent was obtained from all individual participants included in the study.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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