Emotional Eating: Women and Food

– *A comforting recipe or a destructive formula?*

SHIRLEY ASHBY

Thesis submitted in partial fulfilment of the requirements of

University of Kent for the degree of

Doctor of Clinical Science

(Psychotherapy)

APRIL 2013

Centre for Professional Practice

University of Kent

Canterbury

Acknowledgements

I would like to thank Professor Jan Burns for helping me to put the pieces of my jigsaw together. Her insight, challenge and support were invaluable. She guided me over "Mount – where are we going?" and through the "Canyon of Despair", (Harburg & Stallman, 1966), and for that I am truly grateful.

Thank you to all the women who took part in this study and who shared with me their inner most worlds.

Finally, my heartfelt thanks go to my family and friends who have constantly believed in me.

For my family

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Abstract:

The aim of this study was to investigate the discourses women use to describe their eating patterns in relation to comfort eating. The idea originated from the work of Susie Orbach (1978) which focussed upon women's eating patterns and 'fat' being rooted in powerlessness and self-denial. After undertaking a thorough search of the literature, the gap around emotional eating became apparent. This thesis examined the concept of women's relationship to food, and explored if, and if so how, women acknowledge emotional regulation through food and comfort eating.

A qualitative research strategy was adopted. The process of data analysis consisted of 2 phases; phase 1 was a preliminary internet based collection of data and analysed using Thematic Analysis, and phase 2 was in the form of semi structured interviews and analysed using Foucauldian Discourse Analysis from an ontological framework of Social Constructionism.

Overall, the multiple discourses in this study found that participants acknowledged the use of food for 'comfort', and that emotional distress was a mediator when describing their relationship to food. Participants constructed positions associated with; repressed anger, feelings of shame and failure to achieve an ideal, and lack of self-efficacy. This study also highlighted discourses around participants experiencing a non- tangible overwhelming 'urge' to eat that felt uncontrollable. This was in line with a sense of depleted energy and an inability to achieve the goal of weight loss.

This study suggests that medium to long term psychotherapy could be a way forward to address the internal conflicts and inability to change highlighted in the participants' discourses. Inclusion of Psycho-education is also recommended for weight loss management groups in order to address the problematic area of obesity.

Key Words: Emotional Eating, Comfort Eating, Women, Food

1. Introduction

Is Fat Really a Feminist Issue?

....."our three basic needs, for food, and security and love, are so mixed and mingled and entwined that we cannot straightly think of one without the other". (Fisher, 1976, in; Chernin, 1986, p.97)

The thematic direction of this thesis was initially born out of the work of Susie Orbach asking the question "is fat really a feminist issue"?

In 1978 Susie Orbach first published 'Fat is a Feminist Issue'. This book was predominately a self-help guide for women who were 'compulsive eaters' and went on to revolutionise the way we think about being 'fat'. The book offered a new perspective on women's eating patterns and the cover promised women that they could 'lose weight permanently – without dieting'. It offered a psychoanalytic account of what Orbach defined as 'compulsive eating', and explored why women may fear thinness, and might actually want to be 'fat' on an unconscious level. Orbach proposed that women may be meeting their emotional needs through food and body image. Heenan (2005) explains that Orbach's views were two fold. Firstly they were feminist, incorporating an awareness of social conditions, and secondly the perspective was psychodynamic, looking at how social processes influenced women's emotional processes. The argument presented was that women placed their own needs second or denied them completely, whilst at the same time nurturing others. The overarching message was that women were "starved for affection, through emotional overspending and undernourishment" (Heenan, 2005, p.239). 'Fat is a Feminist Issue' has become a seminal text about women, body issues, feelings, fat and eating.

Orbach (1994b) recalls that when she first became aware of women having a troubled relationship to food there was no general information, and very little technical literature available. However, in the 1970's, The Women's Liberation Movement provided Western women with a new way to think about their individual

experiences. They came together in small groups to discuss various topics, one of which was "how their gender experiences had moulded a particular self- identity" (Orbach, 1994b, xii). At the heart of these identity feelings lay the lack of entitlement, neediness, dependency, taboos on anger and the confusion that surrounded them. The thesis laid out by Orbach in the 1978 text also proposed that women were conforming to a strict gendered identity and therefore lacked self-expression. The focus for this lack of self-expression was 'body image' (Orbach, 1982). The woman's body became a "mouthpiece through which women's language is extended" (Orbach, 1994a, p.ix) and "conflicts were played out" (Orbach, 1994b, p.xii). Food became the "weapon" (ibid). Women understood that "food is love" and can soothe emotions when given to others, but food is "dangerous when she eats it" (ibid). Women have turned the weapon of food against themselves by "eating, or refusing to eat, to soothe themselves" (ibid) and say with their bodies "what dare not be heard and daren't be said" (Orbach,1994a, p.ix). Body image subsequently became one of the focal points of Orbach's future work.

Eating disorders are according to Orbach, a social problem. She explains, instead of telling one another about the desperation of the feelings of impotence we say 'I wish I were thin'. Orbach believes the body is a form of language and that the female body equates fat with power, with presence, with a demand to be seen, a way to keep vulnerabilities hidden (Gingold, 2012). Orbach (1994a) states that women do not feel entitled to eat and take food for granted, they cannot respond to hunger, they cannot give to 'self'. Therefore she believes to pathologise women with eating disorders is wrong. So is Orbach correct? Do women grow fat or thin as an expression of supressed emotions? Are women getting their needs met through eating as they are not getting them met any other way? And does a woman's body really "become the text on which they inscribed their relationship to self and others" (Orbach, 1994b, p.xii). Let us examine this argument firstly, by looking at what the psychological studies have told us about our relationship to food and our psychological well-being, that is, the theoretical explanations for eating behaviours.

2. Theoretical explanations for eating behaviours

2.1 Historical review

Despite numerous attempts to understand the concept of disordered eating and obesity, there is little agreement among researchers over the central etiology and treatment techniques. Yates (1989) reported that the first documented case of an eating disorder goes back as far as 895 A.D., with the case of Friderada, then, in the 13th Century women were reported to have starved themselves and, in 1714 Morton studied a young woman suffering from Anorexia Nervosa (AN). After the work of Morton, it was not until the late 19th Century that Gull (1868) in England and Lasegue (1873) in France started to clearly describe patients with AN (Yates, 1989).

Within psychoanalysis, Freud first referred to 'hysterical vomiting' in the case of Dora in a letter to Fliess, in 1899 (Freud, 1899 in; Jones, 1955) later, 1944, Binswanger made an anthropological clinical study of Ellen West, which stood almost alone in the literature on eating disorders (Orbach, 1994b). During the rest of the 1940's psychoanalysts began to look for psychodynamic concepts to explain the phenomena of AN (Yates, 1989) and in October 1947, Hilde Bruch gave her address before the New York Academy of Medicine on the "Psychological Aspects of Obesity". The 1950's and 1960's however, brought a rapid increase in eating disorder literature. In psychiatry Peter Dally published his first paper on Anorexia (Dally & Sargant, 1960) and later, in 1973 Hilde Bruch wrote what became a seminal text, "Eating Disorders, Obesity, Anorexia Nervosa, and the Person Within". The 1980's led to bio-behaviourists starting to research into neurological and genetic reasons for a vulnerability to disordered eating behaviours (Yates, 1989).

According to Slochower (1987) eating disorders seem to encompass three main factors, psychological, behavioural and physiological all of which interrelate. Yates (1989) however, added a further factor to Slochower's work with the inclusion of a

psychosocial factor. I am going to look at these four factors under three overarching headings, the definitions of which are as follows;

Psychological – (split into two subdivisions)

> **Interactional theories** - encompassing a child's earliest relationship with its caregiver.
>
> **Learning Theories** - looking at a person's inability to recognise hunger cues, as in learnt observable behaviour, and aims to restructure dysfunctional beliefs.

Both these processes are dynamic and interpersonal.

Physiological - exploring the organic process of how dietary rules and regulations put upon individuals may lead to weight gain.

Psychosocial/sociocultural - exploring the social and cultural factors which see thinness in women as equating to success, for example, media influences.

Alongside the theoretical explanations there are some fundamental mechanisms by which they work. I am therefore choosing to structure this section in a way that will provide a theoretical conceptualisation of eating disorders and their mechanisms. I have organised the structure into three areas in which the main theories will be explored, followed by the main mechanisms by which these theories work. I also acknowledge that there is a cross over within these structures as the boundaries between the three theories are permeable.

2.2 Psychological Theories

2.2.1 Interactional Theories

The four main interactional theories that explain eating disorders are, psychodynamic, object relations, developmental and attachment theories. An overview of each theory will now be explored. However, it must be noted that although these are the theories that are most relevant to the content of this thesis, they are not the full range. For example, Klein (1952) and Kohut (1971) also provide theories of disordered eating, plus Brandao et al. (2002) and Minuchin (1975) give a family therapy perspective.

Psychodynamic Theory:

Psychodynamic and Psychosomatic theories of eating disorders hold that an obese person eats in response to emotional distress and, the overeating reduces anxiety and depression (Allison & Heska, 1992). They ascribe obesity to a fixation at the oral stage brought about by experiences during infancy (ibid, p.28) and/or a form of hysteria, a drive or defence model surrounding unresolved 'Oedipal' wishes (Freud, 1905). Early writers put forward that the central tenet of the psychodynamic model was that overeating is a "primary response to anxiety caused by unconscious conflict that may temporarily relieve affective distress" (Slochower, 1987, p.145). However, most psychodynamic theories no longer focus on a particular trauma during one of the specific Freudian developmental stages, but focus more on the necessary steps for progression to maturation and what hinders or helps this process. The focus is on the on-going interactions between mother and child and the environment (Bruch, 1973 p.63).

Object Relations Theory:

The feminist psychoanalytic psychotherapists, Orbach (1978), Lawrence (1987), Bloom et al. (1994) and Farrell (1995) all drew their theories from the British object

relations theory (Greenberg & Mitchell, 1983). They argue that eating problems demonstrate ways in which conscious and unconscious gendered feelings about women are split off and projected into their bodies and food. Women negotiate and express their identities through their bodies. Heenan (2005) states, that the body is an interface between the conscious and unconscious mind within both an internal and social world. Object relations theory suggests that there is a symbolic connection between an infant's primary caregiver and food, and that this continues to play a significant role throughout one's life. The feeding process, psychoanalytically, involves both physical consumption and "unconscious introjections of the relationship between infant and caregiver" (Heenan, 2005). This theory easily explains how food becomes a relational experience onto which we can project (ibid). Eating disorders encode and narrate a relational story, one that comes from early intersubjective mother infant interactions and leads to complexity around the meaning of 'desire' (Ferguson & Mendelsohn, 2011). From a relational perspective, a person with an eating disorder organises their subjective experience of desire and agency within their relational context, they turn to food to circumvent the need for "human responsiveness" and therefore protect themselves from "further disappointment" (ibid, p.354).

Developmental Theory:

Following on from psychodynamic and psychosomatic thinking, Hilde Bruch (1973) concentrated her work on the developmental stages and put forward that the obese confuse hunger with negative affect. She identified interpersonal factors which she argued were the fore runners to developing eating disorders (Yates, 1989). Most would agree that Hilde Bruch (1948, 1973) has had a larger impact on the way psychotherapy is practiced with eating disordered patients than any other writer. She gave us a new theoretical understanding of AN, which Swift (1991) believes to be the prototype of all psychologically determined eating disorders, and focused upon psychological deficits in self-development in the dyadic mother child relationship. In the seminal text of 1973, Bruch emphasised pre oedipal development and a deficit in the sense of identity and autonomy. In her view eating disorders symbolise an underlying sense of powerlessness which she traced to the

failures of the mother to respond appropriately to an infant. Personality develops out of the dynamic interaction and experiences of the child with the people in their environment; therefore, if a child lacks any essential tools for important developmental steps, such as lack of awareness of their own thoughts and actions, they are incapable of effective self-assertion (Bruch, 1973). Bruch's theory also lends itself to more of a behavioural theory which will be discussed later.

Attachment Theory:

The importance of how caregivers look after us has been extensively researched over the past 50 years. The theory of attachment developed by John Bowlby (1969) is well accepted and postulates a universal human need for a child to form close affectional bonds with a primary caregiver. Put simply, if a child does not have carers who have helped them to manage their feelings, it is likely that they will have great difficulty in managing these feelings in adult life (Goleman, 1996). By having a good early experience of caregiving a child will develop a capacity to 'self soothe', if this is lacking, the self-soothing may occur with the aid of food. Emotional responses such as anger/sadness/disappointment and excitement and so on need to be taught. If a child lacks appropriate emotional education they will be less able to take care of themselves and feed themselves appropriately in adult life, and may use food to self-soothe or as a self-medicating function (ibid). Therefore, it appears paramount that a mother or primary caregiver helps the child to establish inner states such as being hungry or sated. Early experiences of hunger and food are not always straightforward. Winnicott (1960) argues that if we do not meet our baby's needs for food soon enough and accurately enough, it will bring about distress in the infant. He calls this the "facilitating environment" (ibid, p.223) and "primary maternal preoccupation" (ibid, p.52). Let us now look at the mechanisms by which these four theories work.

Interactional Mechanisms:

Winnicott (1990) argued that an infant's wish for, or rejection of, specific foods could represent attempts to establish a sense of self. Lerner (1991) working with patients

diagnosed with a sub-clinical eating disorder, found that all patients had disturbances in "essential aspects of their relationship with mother", the needs of the mother became the dominant focus of the relationship with very little significance placed on the needs of the child (p.119/110). Lerner's patients had a marked tendency towards compliance and accommodation in interpersonal relationships and were "special" in relation to their mother. They were verbally advanced and intelligent children, yet, underlying this; their part in the mother - child relationship was characterized by "joyless compliance and pseudoindependence" (ibid, p.111). Success was often experienced with panic and these patients presented with a "false self" (Winnicott, 1960). In all these cases the natural narcissistic need for empathic mirroring by a caring agent had gone awry (Lerner, 1991). The developing personality had suffered severe deprivation in the areas of narcissism and object relations, they did not have a reliable, "good enough" (Winnicott, 1971) mother available during the symbiotic phase nor "usable objects" (ibid, p.86). Without this "good enough" mothering, psychodynamic and psychosomatic theorists believe, the ability to self-regulate and deal with internal tensions is compromised leaving the child unable to build a sense of self and self-esteem. The result of this being that the child is left feeling unable to self sooth, incompetent and ineffectual, the internal state is one of hunger, emptiness and restless boredom (Yates, 1989). Naming these feelings is the result of a "good enough" (Winnicott, 1960) caregiver and environment.

2.2.2 Learning Theories

Learned Behaviour Theory:

Overeating can be seen as a learned behaviour that becomes a way of life, and these behaviours are thought to be learned in the family during childhood (Krieshok & Karpowitz 1988). Goodspeed Grant (2008) cites Baldaro et al. (2003) stating that this learned behaviour may occur when children are given food instead of other kinds of attention when they are stressed or as a reward. Central to Bruch's theory was that a mother or caregiver is either, responsive or stimulating, appropriate or inappropriate, and, depending on whether it serves the infant's development or

distorts it, these responses are significant building stones for the development of self-awareness and self-effectiveness. By the mother offering food in response to signals of nutritional need, the infant will gradually learn the sensation of hunger and satiation and differentiate this from other tensions and needs. However, if a child is receiving food as a pacifier (ignoring the real reason for discomfort), as a reward for compliant behaviour, or food is withheld as punishment, a child will grow being unable to differentiate between these various needs. If on the other hand mother offers food for non-nutritional needs the child's ability to recognise the signs will be distorted and confused, resulting in her not being able to discriminate between nutritional needs and some other conflict or tension. By responding too quickly to an emotional state with food, the child may well prematurely cut off the affective experience, therefore, over time the reliance on eating to "explain and cope with internal affect would undermine the child's ability to accurately perceive and to differentially label affect" (Slochower, 1987, p.151). According to Bruch (1973, p.58) this could result in feelings of helplessness in controlling biological urges and emotional impulses. She drew a similarity between the anorexics who declared "I do not need to eat" but have, at times, overpowering urges for food, and the obese patients who recognised "my stomach does not need it (food) but my mouth wants it" (ibid, p.45). The latter group she found was driven to eating against their wish to gain weight and they experienced neither hunger nor pleasure or satiation when eating this way. Any temporary relief from anxious and depressive feelings is short lived and this leads to the "cycle of not feeling right and unsatisfying eating being endlessly repeated" (ibid, p.45).

In order for 'normal' development to occur a mother or primary care giver must acknowledge and endorse both the child's existence and internal world, this is done by responding accurately to the child's bodily needs. If however, the care giver superimposes their own perceptions of the child's needs, inaccurately, then the child is unable to learn who she is, how she feels, or what it is to be satiated (Bruch, 1973). The result of this inability to attune to the child's needs will result in the child adapting and attending to the needs of others in a compliant manner at the detriment of her own needs. This learning process continues throughout childhood and has its emphasis on "what fails to go right" (ibid, p.57) and not on a particular traumatic

event. The obese person is "haunted by the fear of starvation" just as the anorexic person is "oblivious to the pains of hunger" (ibid, p.56).

Cognitive Behavioural Theory:

The clinical approach of CBT is a process of cognitive conceptualizations, of planning treatment, structuring sessions and diagnosing problems. It deals with the patient's present and future rather than their past and believes that recovery is well within the reach of most people. CBT was developed by Aaron T. Beck at the University of Pennsylvania in the early 1960's and was originally presented as a short term structured psychotherapy for depression which sought ways to produce cognitive change that would, in time, bring about emotional and behavioural change. Subsequently, Beck and others adapted CBT to meet a diverse set of psychiatric disorders including eating disorders. In the late 1970's, the CBT model was further developed by Fairburn (Fairburn, 1995). It was designed to cover treatment for the full range of eating disorders and links cognitions, emotions and behaviour. The theory purports that there are a network of common, interrelating maintaining mechanisms that are involved in and account for the persistence of eating disorders. Fairburn's approach used the original cognitive techniques and combined them with the behavioural approaches to the treatment of obesity (Fairburn, 1995).

CBT has been found to work specifically well for bulimia nervosa (BN) and more recently has been extended to include binge eating disorder (BED) based upon the manual of Fairburn et al. (1993). CBT teaches patients how to "modify their dysfunctional thought processes" (Moorey, 2000, p.255), and to identify, evaluate and respond to these processes by targeting specific symptoms or behaviours. The therapy aims to restructure the dysfunctional beliefs about food, weight, body image and self-worth with psycho-education, self-monitoring, changes in eating patterns, problem solving, self-control strategies, and cognitive restructuring.

Following on from this, in 2002, Fairburn, Cooper and Shafran started to explore the psychopathological processes that account for the persistence of severe eating disorders. The approach extended the original transdiagnostic model and addressed the core eating disorder maintaining mechanisms, which cause an obstacle to change. Fairburn's research showed that there were other maintaining processes that patients use, which interact with the core eating disorder maintaining mechanisms. This resulted in the focus of Fairburn's theory being extended to embrace four additional maintaining mechanisms; clinical perfectionism, core low self-esteem, mood intolerance and interpersonal difficulties (Fairburn et al. 2002). Within all eating disorders Fairburn found that there are shared and distinctive features of disturbed eating which are all maintained by similar psychopathological processes. This resulted in Fairburn et al. (2002) combining Interpersonal Therapy (IPT), within the transdiagnostic model in order to find a potential resolution of interpersonal difficulties in patients.

Heenan (2005) suggests that to combine CBT interventions with a feminist psychoanalytic framework is crucial in order to "provide a structure in which food, eating and body size come to be seen as meaningful" (ibid p.159). Maybe the introduction of IPT into Fairburn's transdiagnostic model will go some way to achieve this and start to integrate the behavioural, physiological and interpersonal theories.

Behavioural and Developmental Mechanisms:

Bruch (1973) defined hunger as a physiological state of nutritional depletion or severe deprivation, a psychological experience, the complex sensation an individual feels when deprived of food or as a symbolic expression of a state of need in general. She combined developmental perspectives with a learning theory perspective. Hunger is a universal phenomenon which everyone experiences, but in disordered eating there seems to be a basic disturbance in the way the sensation of hunger is experienced. There are symbolic meanings attached to disturbed food intake which can be recognised in both AN and obese patients alike, both have either a "voracious uncontrollable intake or a rigid refusal to eat" (ibid, p.44). Bruch's

work asked the question, how was it possible for a bodily function as essential and basic as food intake, to develop in such a way that it could have been misused in the service of non-nutritional needs (ibid, p.44). She states that the experience of hunger is not innate, but contains important elements of learning; something has gone wrong with a person's ability to recognise hunger and satiation (ibid, p.45). The deficit in awareness of internal hunger and satiated cues ultimately lead to weight gain and obesity (Bruch, 1973). As early as 1947, Freed undertook various clinical trials on 500 obese women and found there was increased eating when nervous, they ate more when bored, and the emotions that were most frequently associated with overeating were depression and anxiety.

Stunkard (1959) from a behaviourist perspective looked at eating patterns and obesity and described three eating patterns; "night eating during stress, binge eating associated with life stress and eating without satiation"; this however does not fully address the question of eating in response to affect regulation, but rather a presence or absence of certain behaviours. Following on from these studies though, Bruch (1973) and Slochower (1987) found that shifts in the emotional state of a person did result in overeating patterns, and was an "attempt to control the overwhelming internal anxiety states" (Slochower, 1987, p.152). An early feeding experience where food is used to pacify, subdue, or comfort a child, interferes with the perceived association of hunger and eating - the child "becomes unable to differentiate between hunger and emotional stress" (Slochower, 1987, p.151). Hunger is something an infant cannot name, but, the intensity of the feeding experience stays with us in some preconscious or non-verbal way (Buckroyd, 2011).

2.3 Physiological Theories

A change in eating behaviours can have an impact upon a person's physiological state. Interfering with a person's physiology as a result of indulgent eating patterns will in turn impact upon their satiation and result in physiological change (Brownell, 1986).

Physiology and Eating Behaviour Theory:

The effects of dietary restriction have been explored for more than 50 years. Keys, et al. (1950) reported that participants after restrictive dieting had a preoccupation with the thought of food, loss of control around eating, profound emotional changes and depressed mood (Warren & Cooper, 1988). Warren & Cooper (ibid) basing their own research on this work found that 'normal' dieting has similar consequences leading to a vulnerability to overeat, a preoccupation with thoughts about food and eating, urges to eat and feelings of being out of control of their eating, that is, feeling unable to stop. They found no significant gender differences. Dietary restrictions placed upon obese individuals often result in a preoccupation with food and have been found to be predictive of an increase rather than decrease in body weight (Swinburn & Egger, 2004). Most obese individuals who initially lose weight on a diet, that is, the restriction of food intake for weight loss, will regain weight plus more within four or five years (Garner & Wooley 1991, p.736). Not all diets fail, but Garner (1995, p.945) argues that most do in the long run. However, far from studying who should diet, in what way, and with what mind-set, Wooley (1995, p.944) argues that researchers must concentrate more on the *process* which underlies much of the disturbances in the area of obesity. Having established that restrictive dieting can lead to emotional changes; let us now consider how this can lead to weight gain. Nesbett (1972) explains that human beings have a physiologically determined base level or "set point" (p.435) of fat stores which counteract an individual's effort to change weight through dieting. In fact, repeated dieting may result in a higher 'set point' by storing fat (Brownell et al., 1986).

Weight Cycling Mechanism:

Brownell et al. (1986) undertook a study examining the metabolic and health effects of weight cycling, (repeated cycles of weight loss and regain), also known colloquially as "yo-yo" dieting (ibid). They found that patients who had dieted many times in their lives had the most difficulty losing weight. The reason for this being that they had a low metabolic rate, that is, the rate their bodies used up energy from food. The paradox that dieting could actually inhibit later weight loss was further researched by Brownell et al. (1986) focussing upon "yo yo" dieting. Rats were put

on a high fat diet until they became obese, then placed on a balanced weight loss diet until they returned to their normal weight. This cycle was repeated twice. The results were that the rats needed 21 days to lose their excess weight during the first cycle, but after regaining this weight, it took them 45 day to lose their weight the second time. To regain the same weight in the second cycle it took only 14 days. The weight loss was twice as slow and weight regain was three times faster during the second round of "yo yo" dieting. Subsequently to this, the rats were able to maintain their body weight on fewer calories. It was concluded that weight cycling could in fact contribute to obesity by altering the body composition, and allowing the storage of fat to be more efficient by increasing the Lipoprotein Lipases enzyme (ibid). As fat is less metabolically active than muscle, it appears the more fat we store, the lower our metabolic rate. Interestingly, the study also found that after weight cycling, the rats strongly preferred more fat in their diets.

Most of the clinical studies carried out on 'yo yo' dieting are with rats or mice due to the ethics and harmful nature of asking people to lose and regain a lot of weight repeatedly (Brownell, 1988). However, Brownell's study of rats, led to a five year Weight Cycling Project (ibid) with humans. Each participant had lost weight and regained some or all of the weight, then enrolled for a second time at the original clinic. The results for all participants after the second weight loss attempt were significantly lower than the first, (2.1 lbs per week on the second diet compared to 3.1 lbs per week on first diet) (ibid). Studies into the effects of weight cycling on the human dieter have been limited, and the results of the aforementioned study have not been documented specifically in one paper. However, the data was collected and reported in various other studies which suggested that frequent dieting may make subsequent weight loss more difficult (Blackburn et al., 1989) and that weight cycling could actually contribute to obesity in humans,(Brownell et al., 1986) resulting in a strong link to dieting having a negative effect upon our health. If a function of dieting leads to emotional eating and preoccupation with food, and the facts are that obese individuals are more likely to be dieting, this clearly links emotional eating with obesity (Allison & Heshka, 1992 p.293). Nearly all the data used to discuss the effectiveness of dieting is coming from clinical studies with mild and moderately obese people (Garner & Wooley, 1991, p. 730, Brownell & Rodin, 1994, p. 785).

Because many dieting individuals are not obese, Brownell & Rodin (1994) suggest that the normal weight population must be studied to develop a clear picture of the effects of dieting.

2.4 Psychosocial Theories

Social and Cultural Theory:

As previously stated, the boundaries between the theories of disordered eating are permeable, however, Orbach (1982) appears to disagree with the basic tenets of Bruch's work, expressing that female fatness and obesity are an expression of pain and conflict, and that overeating is rooted in a woman's social inequality. Social factors, and the equating of thinness in women with success, contribute to the psychosocial theory of eating disorders. The predisposition to an eating disorder comes from a strict diet in response to social and cultural pressures, which then becomes a self-perpetuating, and reinforcing process with its own mental and physical pathology (Yates, 1989). This is also central to Orbach's (1982) theory that fat is a social disease, and hence, "fat is a feminist issue". Unlike other psychological theorists, Orbach, coming from a feminist psychoanalytic perspective, went further than positioning overeating and obesity to being simply something lacking in the individual, but set it in a wider context and made her central theme that fat is about protection from "society's sexual stereotypes and limited options for women" (Probyn, 2009, p.117) as well as being an expression of painful, conflicting experiences (Orbach, 1982, p.17). The central tenets of the psychosocial theory are that fat is a way of overcoming powerlessness and self-denial (Orbach, 1982, p.33). The feminist writers define fat as being about protection, sex, nurturance, strength, boundaries, mothering, substance, assertion and rage. They ask the question, what is it about the social position of women that leads them to respond to it by getting fat (Orbach, 1982, p.19). The feeling of powerlessness however, does reflect the inability of a child to meet her own needs or have her needs met, thereby feeling impotent and powerless in the mother child interaction as described by Bruch.

Probyn (2009) argues that Orbach's central messages have been further translated however, into the idea that acceptance of being overweight and obese is the goal (Le Besco, 2009, Rice, 2009). The movement of fat acceptance has become powerful and has drawn inspiration from feminism, but, according to Probyn (2009) many women have and still do find "solace" in Orbach's central message that it is "not in women's interest to be fat" (ibid, p.118). Social and cultural messages about a woman being expected to shape herself to an externally imposed image, which leads to her becoming a wife and mother who puts everyone else's needs first, are at the forefront of the feminist thinking. Orbach (1982) argues that buying and cooking food being usually a woman's role, becomes part of her providing love and care for her family; she goes on further to say that this includes "subordinating their need for food to men and children" (Sayers, 2009, p.30). In these generalised statements Orbach argues that women teach their daughters to subordinate their needs, which results in girls growing up unable to recognise hunger signals. Orbach continues that women's fatness is a resistance to this process resulting in women indulging their needs by bingeing and comfort eating (Sayers, 2009).

Maine & Bunnell (2008) go further and suggest that women convert the pain of being pushed into being separate in adolescence, and to move away from the comfort of the mother/child relationship, into disordered eating (ibid). They argue that disordered eating is contextualised as a sociocultural problem with the focus being on unhealthy pressures on an individual. Like Orbach, they state that a woman's disordered eating is a response to confusing, conflictual experiences which she cannot master any other way. However, the issue of gender being one of the mechanisms by which the social and cultural theory operates needs to be briefly considered here; does Orbach's theory of women and obesity still stand today?

Gender Mechanism:

The National Obesity Observatory, (NOO, part of Public Health, England), which makes international comparisons of obesity prevalence, has statistical data available for England from 1995. Therefore there was no statistical evidence available, female

or male, for the prevalence of obesity in 1978 when Orbach wrote her thesis. However, generally both male and female obesity figures are growing. The percentage of the adult population who were considered obese, (BMI of over 30Kg/m^2), between 1995 and 2007 rose from 16.4% to 24% (www.noo.org.uk) and the trajectory for obesity prevalence by 2025 and 2050 is 40% and 60% respectively (www.defra.gov.uk). The statistics for the levels of obesity in both men and women in 2013 are not very different, apart from men are reported to be 'overweight' (41%) as opposed to 'obese' (24%) (www.ic.nhs.uk) but despite demographics getting more equal and men in future looking like they may be more at risk, we still have an emphasis culturally and emotionally on women. One argument to consider is that women are more likely to be dieting and this, as we have seen, could lead to increased obesity.

Socio-economic Mechanism:

Another aspect is that obesity, although historically has been associated with economic affluence, is now also associated with poverty (Wells et al., 2012). In a recent study, looking at obesity prevalence across 68 countries, Wells et al. (2012) found there were 3 obese women for every 2 obese men, and that there were significant gender differences in the association of obesity and socioeconomic factors. They state that countries characterised by gender inequality and lower GDP (per capita, gross domestic product), had an excess of female obesity (ibid). Considering the wider contextual issues, there now exists a whole body of literature talking about fat being economic and political, not just personal. Therefore, although more recently Orbach continues to argue her point that eating is a real problem, "inflected with guilt, confusion, and regret and worry" (Orbach, 2006, p.68) and her point of attack is still the body-image industry, how much relevance has Orbach's thesis got now given the wealth of research and changes for women since 1978? Fat is a feminist issue's enduring legacy can still be seen in today's society, as it is now almost a catchphrase in the English language but, if fat is a 'feminist' issue then why are men also fat? Clearly further work needs to be done on the relationship between gender and obesity as obesity is increasingly layered by socio-economic factors, westernisation and capitalism. Perhaps 'fat' is now also an economic issue?

Interestingly, Orbach herself now links obesity with capitalism and purports that fatness is an "indictment of our culture", and goes on that we need to take note of "class issues and how aspiration plays out for many who experience economic exclusion" (Orbach, 2010, p.102).

Let us now look at what constitutes a 'clinical' eating disorder in order to clearly identify what is meant by 'clinical' diagnosis as opposed to 'theoretical' explanations for eating disorders.

3. Definitions and Epidemiology of Eating Disorders

"Eating is normal, in that it is a human necessity; having an eating disorder is not." (Farrell, 1995).

The term 'anorexia nervosa' was introduced by Gull (1868) and Lasegue (1873) however, the term Eating Disorder first appeared in the Diagnostic and Statistical Manual 1, (DSM-1), in 1952 where Anorexia Nervosa was listed as a "psycho-physiological reaction". In 1968 it was categorized in the DSM II as a "feeding disturbance". It was not until 1980 in a newly designed eating disorder section that Bulimia (B) was given an entry in the DSM alongside Anorexia Nervosa (AN). The DSM IV (2005) categorises eating disorders as;

> "Anorexia Nervosa – AN (Restricting type and Binge eating/purging type)
>
> Bulimia Nervosa – BN (purging type and non-purging type)
>
> Eating disorders not otherwise specified, EDNOS".

The DSM IV category, EDNOS, which is for "disorders of eating that do not meet the criteria for any specific eating disorder", was found by Turner & Bryant-Waugh (2004) to be the largest single group in research undertaken in a UK Community Eating Disorder Service. They reported that out of 95% of participants studied, 67% were diagnosed with EDNOS, in contrast to 22.5% with BN, 5.5% with AN.

The factor that separates AN and BN in the DSM-IV is the matter of weight, "anorexia nervosa is an eating disorder characterized by the behaviour directed toward weight loss, intense fear of gaining weight, body image disturbance, amenorrhea, and an implacable refusal to maintain body weight" (Eme & Danielak, 1995, p.40). Farrell (1995, p.6) identified anorexic patients as those who are "15%

below normal weight", which is in line with the definitions given by the DSM-IV (2005) however, Shoenberg (2007, p.97) added to the criteria by including a Body Mass Index, (BMI), of less than 17.5kg/m² being an identifying factor of AN. The DSM offers guidelines for making diagnoses by clinicians; its purpose is to provide clear descriptions and diagnostic categories.

The current DSM-IV (2005) lists the main criteria for Anorexia Nervosa as;

A. "Refusal to maintain body weight at or above minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., oestrogen, administration)". (p.251).

The categorisation then divides into two further categories of "Restricting Type and Binge-Eating/Purging Type" (DSM-IV 2005, p.252). Although it is widely accepted that most psychiatric clinicians accept the DSM as the main source of diagnostic tool, it is important to remember that the boundaries between diagnostic descriptions are often fluid and sometimes limited.

Bulimia Nervosa is recognised as those patients who have not got a severe weight problem, neither obese nor anorexic, but exhibit bulimic symptoms such as bingeing and purging. BN is characterised by intense concern about weight; recurrent episodes of excessive overeating accompanied by a subjective sense of loss of

control; and the use of vomiting, exercise, and/or purgative abuse to counteract the effects of Binge Eating (Eme & Danielak, 1995). With BN restrictive dieting eventually gives way to binge eating episodes which are followed by self-induced vomiting (purging). Uncontrollable food consumption is followed by behaviour to rid the body of the excessive calories; this includes self-induced vomiting, excessive exercise or the use of laxatives (Beals, 2004, in; Zeigler 2011). The latter is also similar to the behaviour of some AN sufferers too. Shoenberg (2007, p.110) takes the DSM diagnostic criteria for BN and explains that the patient fears being unable to stop their eating voluntarily, the "binge eating and vomiting relieve tension and anxiety" and therefore become rewarding activities. The DSM-IV lists the main criteria for BN as;

A. "Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following;
    1. Eating, in a discrete period of time (i.e., within a two hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
    2. A 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)
B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
D. Self-evaluation is unduly influenced by body shape and weight
E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa". (p.252).

Again this category is divided further into "Purging Type and Nonpurging Type". (DSM-IV, 2005, p.253). The underlying pathology of BN is similar to that of AN, a "fear of fatness is in conflict with an uncontrollable desire to eat excessively" (Shoenberg, 2007, p.110). Both AN and BN are not exclusive, some patient's eating

oscillates between the main features of both disorders and/or exhibits a mixture of both forms of behaviour (Cajanus, 2009).

The DSM-IV (2005) categorises disorders of eating that do not quite meet the criteria for any specific Eating Disorder as, the Eating Disorder Not Otherwise Specified, EDNOS. The criteria for EDNOS are set out as;

1. "For females, all of the criteria for AN are met except that the individual has regular menses.
2. All of the criteria for AN are met except that, despite significant weight loss, the individual's current weight is within the normal range
3. All of the criteria for BN are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week for a duration of less than 3 months
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g. self-induced vomiting after the consumption of two cookies)
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa". (pp. 253-254).

Binge eating disorder, (BED), has been widely recognized by Christopher Fairburn (1995). Fairburn defines BED as being within the same criteria **1** and **2** previously listed from the DSM-IV for BN, but with the exception that people with BED, according to Fairburn, have repeated binges and they do not take the extreme weight control measure used by people with BN. Fairburn states that people with BED are often called "compulsive eaters". At present BED is listed in the DSM-IV (2005) under EDNOS and not considered a separate clinical eating disorder. However, with the forthcoming publication of the DSM-V in May 2013, the Eating Disorder section is to be renamed "Feeding and Eating Disorders", and within this section BED will likely be recognised as a free standing diagnosis. The DSM-V

proposes to categorise BED as meeting the criteria 'A' (1 & 2) for BN plus;

B. "The binge-eating episodes are associated with 3 (or more) of the following:

1. Eating much more rapidly than normal
2. Eating until feeling uncomfortably full
3. Eating large amounts of food when not feeling physically hungry
4. Eating alone because of feeling embarrassed by how much one is eating
5. Feeling disgusted with oneself, depressed, or very guilty after overeating
6. Marked distress regarding binge eating is present
7. The binge eating occurs, on average, at least once a week for 3 months
8. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior and does not occur exclusively during the course of Bulimia Nervosa or Anorexia Nervosa". (www.dsm5.org).

Following studies, Fairburn & Cooper (1993) concluded that most EDNOS patients had mild AN or BN and that both full and partial AN and BED appeared quite similar in presentation (Turner & Bryant-Waugh, 2004).

Finally, there is another grouping of disordered eating syndromes that are classified as "subclinical eating disorder", (SED) (Zeigler, 2011). Across the continuum lie a large range of disordered eating behaviors which fall short of the established DSM-IV (2005) criteria for one of the three clinical conditions. Zeigler (2011) explains that individuals who fall into this SED category may move along the continuum from unhealthy to healthy eating behaviours and back over time. The unhealthy behaviours include; "excessive dieting, fasting, extreme body dissatisfaction, binge eating, compulsive exercise and purging" (Zeigler, ibid). Farrell (1995, p.xi) describes SED as a "new and disturbing fact of life" from which it was estimated at that time, 80% of women in the UK suffered (Coward, 1993 p.157). SED does not threaten life but is a low-key persistent form of eating disorder.

Coward (1993) recognised SED as a "dieting-related syndrome" (p.157) and described SED as a "disordered relationship with eating and a distorted relationship

to food", she explains that with SED typically, "women embark on rigid diets, virtually starving themselves for a few days and then giving into cravings, bingeing on 'unhealthy' foods like chocolate or pizzas" (ibid). Farrell (1995) concurred with this calling one strand of SED "yo yo dieting". In Farrell's opinion SED is a 'disorder', as she believes that the effects of persistent and intermittent dieting produce similar symptoms in an individual as starvation does (Farrell, 1995). The blurred boundaries between dieting, SED and full blown eating disorder, is the distinction between the degree and the nature of the preoccupation with eating, food, weight and body image (Farrell, 1995, p.xii). Although less intense, SED patients present with "disturbances in eating, self-regulation and control", similarly to AN and BN (Lerner, 1991, p.109).

There is a wealth of research material into AN and BN and much less research into SED, but Zeigler (2011) places SED within the eating disorders classification and, looks at it as being only a step down of severity from the clinical eating disorders of AN and BN. Therefore if we are to look at Ziegler's continuum from Orbach's perspective, this whole approach to characterise eating behaviours is to pathologise them, and it could be argued that Zeigler has added to this by inventing yet another category by which women can be pathologised.

If we take Zeigler's continuum and visualise it in a slightly different way, (see fig. 1 below), we can see a clear graduation of severity of the disorders and their set of symptoms. The space or gap that lies between SED and normal eating could be where the non-clinical disordered eating patterns of emotional eating (EE), including BED, may sit. In the continuum below, we can clearly see the eating patterns running through from normal eating behaviours to EE, with SED falling between EE and the more severe end of the continuum , the clinical eating disorders of AN and BN.

Continuum of Disordered Eating

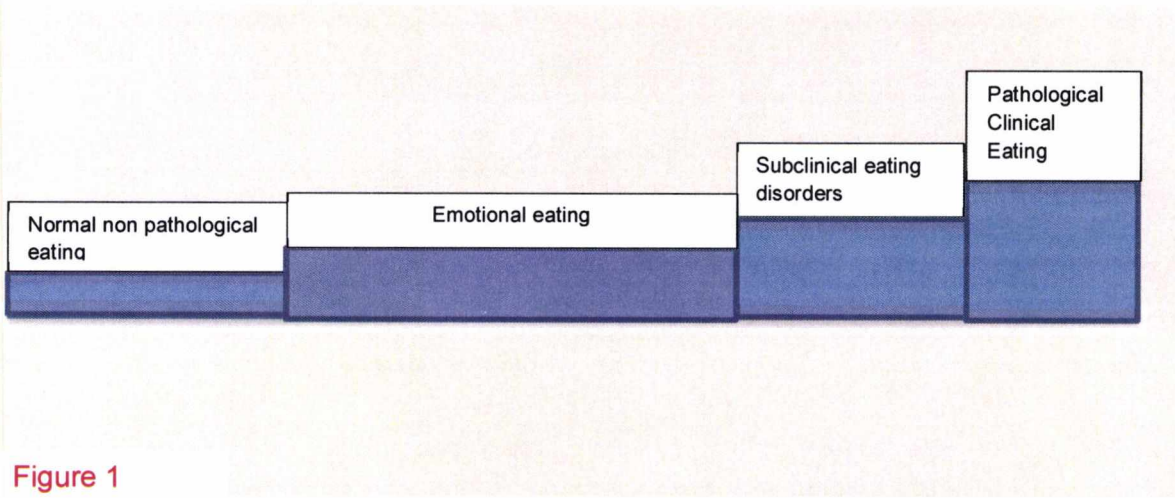

Figure 1

→ → → → **Severity** → → → →

The dispute obviously lies in where do we draw the line between pathological and non-pathological? What is clear however, is that there is no hard and fast lines of demarcation, but a continuous theme that crosses all categories of disordered eating; that of managing emotions through eating. Eating becomes the 'function' undertaken in order to manage emotions. For the 'forms' of disordered eating across our continuum, on the milder end nearer to 'normal eating', the functional way of eating tends to provide comfort and reward, giving to your 'self', a way of behaving that is rewarding to 'self'. Whereas on the severe clinical end of eating disorders, as in AN (far right), there is a negative function, a negative giving to 'self', a punishment, even a taking something away from 'self'. BN seems to oscillate back and forth between the two, between binging (giving) and restricting (punishing) functions. Let us now look at some of the non-clinical eating behaviours that could come under the heading of 'emotional eating'.

4. Further, non-clinical definitions and considerations

4.1 Comfort Eating

After undertaking a literature search of comfort eating, there was very little information found, however, a further literature search on Emotional Eating was undertaken and this produced more. Whilst the phrase 'comfort eating' is currently used in the vernacular, emotional eating tends to be the phrase used in the research and clinical world, however the two basically mean the same. Interestingly, the literature pertaining to both of these phenomena was still less than that found for the usual diagnostic categories of Eating Disorders. Given this, it is difficult to find clear definitions available to really define the phenomenon of comfort eating. However, the Webster's New World Medical dictionary (www.medterms.com 2013) defines Emotional Eating as, "the practice of consuming large quantities of food – usually 'comfort' or junk food – in response to feelings instead of hunger", and the Oxford English Dictionary (OED), puts forward a definition for comfort eating as; "eating to make oneself feel happier, rather than to satisfy hunger". Both of these definitions highlight a lack of hunger. However, one explanation may be that 'emotional eating' could be seen as a function of a disordered eating pattern, and therefore, comfort eating could be seen as a form of this function.

There have however, been three main studies undertaken into 'comfort foods' and their emotional significance (Dubé et al., 2005, Locher et al., 2005, and Le Bell et al., 2008). All three studies highlighted that the consumption of 'comfort foods' is motivated by the desire to alleviate stress, distress and other negative emotions. All three identified 'comfort foods' as being high in sugar, fat or carbohydrate, with a high calorific value. A study by Dallman et al. (2005) also found this to be the case but further defined 'comfort foods' as dense and nutritionally poor. So what is it about these high sugar, high fat foods that provide comfort? Only one study provided a possible explanation (Locher et al., 2005) looked at the social and emotional significance of these types of foods and concluded that 'comfort foods' are classified into four categories; *nostalgic foods*, - those being identified with a

particular time and place in one's history, *convenience foods* - those which are readily available to provide almost instant gratification, *indulgence foods* - foods rich in terms of either content or expense, and *physical comfort foods* - foods which are easily eaten and digested, often warm with little chewing. They found a difference between men and women in comfort food selection. Within their research, Locher et al. (2005) found that women were more likely to choose comfort foods associated with the preparation of the food *with* a significant other, or foods which they received as a gift (such as chocolates), (p.293) and that men were more likely to choose comfort foods that were prepared by another, either mothers or lovers. There seems to be an interesting discrepancy between women finding comfort in preparing foods *with* another ,and men finding comfort in foods prepared *by* another.

Although this is not covered by the research, these findings go against the common view of comfort eating being in general something women in particular do in secret and when alone. Therefore, there is clearly a difference highlighted here between comfort food *selection* and the act of comfort eating. Locher et al. (ibid) found it noteworthy that not one participant in the study described providing or preparing food for him or herself to provide comfort, but did state they consumed foods associated with some special memories in their history when feeling down and needed comfort. The participants almost always consumed these 'comfort' foods whilst alone, which is in line with readings from other research studies. Locher et al. (2005) suggest that, when we feel isolated, consuming foods that conjure up comfort images helps us to combat the feelings of aloneness. Locher et al. (ibid) also reported that Fischler (1988) saw food object choices as being one primary way in which individuals can exercise control over the body, the mind and therefore, over identity, being the "favored instrument of control over the self" (p.280). They concluded that the social and cultural aspects of food and eating are linked with physical and mental wellbeing. All three studies reported that 'comfort foods' were consumed, in the main, outside of hunger and had little to do with 'feeding functions'. Put simply, comfort eating seems to be eating "a specific food consumed under a specific situation to obtain psychological comfort" (Wansink & Sangerman (2000) in; Locher et al., 2005).

4.2 Limitations of the Studies and Recommendations

Two of the existing research studies used a methodology which was based upon data collected from the internet (Le Bel et al., 2008 and Dubé et al., 2005). Dubé et al. (2005, p.565) acknowledged that the use of self-report surveys, could inevitably entail memory biases, and the use of internet based data collection introduced further limitations to their findings. Le Bel et al. (2008) acknowledged that the impersonal nature of the data collection, may have led some participants to under report weight or over report height which may explain that there were no BMI differences detected between the two female participating groups, both with complex eating schemas, and recommend alternative data collection method for future research. Locher et al. (2005) relied upon young undergraduate students for data collection and acknowledged a limitation of their study was that all participants have the same social, cultural and economic background and come from the same region, which could have affected the particular comfort foods chosen, resulting in a lack of generalisation.

The recommendations for further investigations called for more experimental research including the monitoring of biological states in a more naturalistic environment, and for research to look at, in more depth, cognitive schemas (Le Bel et al., 2008). They recommended research to identify the key mental associations that influence the selection and consumption of comfort foods, resulting in trying to ascertain; a) when and what types of comfort foods are eaten and b) what does comfort food mean to a subject (Dubé et al., 2005). Given that obesity and nutrition related diseases are becoming more prevalent in our society, Locher et al. (2005) called for future research focusing on the role that emotions plays in eating behaviours and food selection, using participants that do not have a clinical eating disorder. Uncovering the social and emotional aspects, triggers or cravings and expectations that results from comfort food consumption (Dubé et al., 2005; Locher et al., 2005) could lead to a deeper understanding of the process of comfort eating.

4.3 The process by which emotions are related to eating behaviours

Given the lack of research into comfort eating, what is starting to become clear is the gap between what constitutes a 'comfort food' and the process of comfort eating. The process, by which emotions can affect certain eating behaviours, is therefore emerging as the unresolved question.

A serious concern about food choices that may have an adverse effect on our health is widespread in the developed world. Recommendations to reduce elements such as salt and fat consumption and increase fibre and complex carbohydrates are the central messages coming from most public health nutritional guidelines (Cannon, 1992). Despite this fact, fat consumption remains the highest in the Western world (Stepto et al., 1995). Cannon, in his book Food & Health - the experts agree (1992) demonstrates the established concerns among the scientific community that the diet typically eaten in industrialised countries such as United Kingdom (UK), is an important factor in major diseases such as cancers and cardiovascular diseases. He surveyed the results of a hundred authoritative scientific reports on food and nutrition looking at the relations between diet and health, and found that relatively small changes in eating habits could produce significant reductions in the UK disease rates. The scientific evidence clearly linked Western diets with typically Western diseases and states that the UK diet is unhealthy as it contains too much fat, saturated fats, sugar and salt. Cannon's work formed the basis of the 1988 White Paper, The Health of the Nation (www.dh.gov.uk) which was the first attempt by the Government to provide a strategic approach to improving the overall health of the population. Evidence exists that, as a nation, we do still have something to be concerned about in relation to our health. The recent Government White Paper, Healthy Lives Healthy People (2011) sets out proposals for a reformed public health system in England. Part of these proposals is to enable adults to change their behaviour in order to reduce premature deaths from cancers, heart, and other circulatory diseases. The paper outlines the critical role of public health. One example of concern in public health is that "two out of three adults are overweight or obese" (www.dh.gov.uk, 2011, p.2.2). It cannot be a coincidence that the types of

foods that we are choosing for 'comfort', are foods that will make us fat, and which may ultimately kill us. Therefore eating becomes self-annihilating.

It is hard to imagine a United Kingdom (UK) society today where people do not worry about their weight. The preoccupation with fat and food has become so common we take it for granted. In 2013 the Information Centre for the National Health Service, (NHS), published a paper, Statistics on Obesity, Physical activity and Diet in England: 2013 (www.ic.nhs.uk). Within this paper the National Institute for Health and Clinical Excellence, (NICE), postulates that Body Mass Index (BMI), in conjunction with waist circumference, should be used as a measurement of the degree of obesity to help determine health risks (p.15). NICE defines a person as obese if they have a BMI of 30-40kg/m^2 (kilograms divided by the square of height in metres), and overweight as a BMI of 25-30kg/m^2 (p.15). The key findings were that in 2011 almost a quarter of men, 24%, and just over a quarter of women, 26%, in England, (aged 16 or over), were classified as obese with a BMI of 30kg/m^2 or over, and 41% of men and 33% of women were overweight. These findings were in comparison to only 34% of men and 39% of women with a BMI in the normal range (p.16). Using both BMI and waist circumference to assess risk of health problems women were 15% increased risk, 18% at high risk, and 26% at very high risk, equivalent figures for men were 18%, 15% and 21% (p.16).

Another research report published in 2008 by the British Medical Journal Group, predicted that the prevalence of obesity would have increased to 32.1% in men and 31% in women by 2012 based on 1993-2004 obesity prevalence trend data (www.ic.nhs.uk p.20). Whilst figures are not yet available, it was predicted that if recent trends continue, approximately one third of all adults in England would be obese by 2012. Obesity figures continue to rise despite medical interventions, and relapse after treatment seems to be the norm (Green & Buckroyd, 2008) 95% of individuals regain the weight loss within 5 years (Mark, 2006, p.123 in; Goodspeed Grant, 2008). The Government Office for Science produced the Foresight Report (www.bis.gov.uk 2007) where it estimates, that if no action is taken tackling obesity, 47% of men and 36% of women will be obese by 2025 (p.20). Therefore, fat is fast

becoming a 'masculine' issue. Extreme obesity is a risk factor for chronic health problems such as type 2 diabetes, high cholesterol and other health issues. Despite knowing the dangers to our physical health, in the UK today we have an obesity epidemic. "The drive to eat is powerful and food and eating behaviours are rife with cultural, social and emotional meaning" (Goodspeed Grant, 2008, p.123).

The World Health Organisation's (WHO), International statistical Classification of Diseases and Related Health Problems (ICD-10, 1994, 4th Ed.) does include obesity within its classifications. Obesity is listed as;

> "E66.0Obesity due to excess calories
>
> E66.1 Drug-induced obesity
>
> E66.2 Extreme obesity with alveolar hypoventilation
>
> E66.8 Other obesity, including, Morbid obesity
>
> E66.9 Obesity, unspecified, simple obesity NOS"
>
> (www.who.int).

The WHO also defines obesity as "abnormal or excessive fat accumulation that may impair health" (www.who.int) it relies on Body Mass index (BMI) to diagnose. The ICD-10 also recognises "overeating associated with other psychological disturbances", and lists as examples, "overeating due to stressful events, such as bereavement, accident, childbirth etc."

Whilst quite a lot of data exists regarding the epidemiology of weight, there is less data detailing the prevalence of clinical eating disorders within the general population of the UK today (www.b-eat.co.uk). The only figures available from the Department of Health are for those severely affected cases which are hospitalised, that is, inpatients in the NHS. The most accurate figures that could be found were from NICE, that suggest 1.6 million people in the UK are suffering from an eating disorder,

of which 40% are bulimic and 50% fall into the category of EDNOS (www.nice.org.uk/nicemedia). The Office for National Statistics figures estimate that in 2011 there were 56.7 million people in the UK (www.ons.gov.uk). Therefore, if 1.6 million people have some type of eating disorder formally classified as an illness, this equates to 2.85% of the UK's population, and 90% of this figure (2.56%) has an eating disorder which could potentially lead to obesity, BN and EDNOS. If, as the statistics suggest 33% of the UK's population in 2012 were obese, but only 2.56% are classified as having any form of clinical eating disorder, that leaves 30.44% of obese individuals not accounted for. Therefore, having an eating disorder does not statistically account for the obesity epidemic in UK today. It seems a little unrealistic to suggest that, because 33% of the adult population in 2012 were overweight, this means they have an eating disorder, but it does however, potentially point to eating being a factor in some type of psychological disturbance. Given that obesity is judged as non-clinical, meaning there is no clinical treatment for such; weight management becomes part of the general approach to our public health. For public health interventions to be effective help is needed in understanding the processes behind non-clinical eating patterns such as comfort eating.

In the Western society it is generally believed that the causes of obesity are overeating and inactivity. Most people assume that inactivity leads to fatness, and as a consequence of this the Government's Chief Medical Officers in 2011 published revised guidelines recommending that adults should reach 150 minutes of moderate activity per week, and children 60 minutes of moderate activity each day (www.ic.nhs). However, a recent study into childhood obesity and type 2 diabetes monitored 300 children over 12 years old (www.earlybirddiabetes.org) and the results challenged widely held beliefs about the causes of weight gain. They found that physical activity had no impact on weight change - but that weight clearly led to less activity. The implications of this study are profound for public health. Fitness levels are crucial for a child's wellbeing, but these may never improve unless the fundamental cause of childhood obesity is tackled. Another important finding to emerge from this study was a strong link between childhood obesity and parental obesity, but only with parents of the same gender. The report found that a daughter of an obese woman was 10 times more likely to be obese than a girl with a mother of

normal weight, also the risk of obesity for sons of an obese father were six times more likely (ibid). However, it must be considered that men are overtaking women in the obesity statistics. Let us now explore whether there are any clear differences between men and women when it comes to comfort eating and comfort foods.

4.4 Gender difference

Gender figures for comfort eating are not available, however, the pattern or template for comfort eating seems to have been developed on women and most self-help books seem to be aimed at women, as are numerous media articles around body image and dieting. There is evidence of many social factors influencing women's feelings about their appearance (Rothblum, 1994); concerns about eating, the body and self-image appear to be woven into women's experiences from early adolescence. In 1994, Dolan & Gitzinger, estimated that 90% of women had been on slimming diets, 20% of normal women binge eat and 10% had used vomiting or laxatives as a method of dieting. More recent figures announced by the BBC news, from a poll carried out by the analysts Mintel in 2004 (www.news.bbc.co.uk) found that 2:5, (37%) of women were dieting most of the time, compared to almost half that figure for men, only 1:6 (18%). The NICE guidelines on eating disorders (2004) postulate that 90% of people diagnosed with BN are female (www.nice.org.uk) and the NHS paper for Statistics on Obesity, Physical activity and Diet in England: 2013 (www.ic.nhs.uk, 2013, p.16) states that women are significantly more likely than men to have a raised waist circumference (47% and 34% respectively).

It would appear from the statistics previously outlined, that more women than men in our society are classified as obese (26% and 24% respectively) as opposed to the figures for being overweight which are higher for men than women, (41% and 33% respectively). However as previously outlined, the Foresight Report (2007) statistics show changes towards obesity shortly becoming more of a male problem. Bariatric surgery (gastric bands) for the treatment of morbidly obese (BMI of 40kg/m^2 or more) was recommended by NICE in 2002 (www.nice.org.uk 2002) and over 4,200 weight

loss procedures were carried out on the NHS from April 2008 to April 2009. These figures rose to just over 7,200 in 2009/10 (www.ic.nhs.uk, 2011). However, from the statistics we could not speculate that women eat more emotionally than men do, but the statistics and what we know culturally about women and food are contradictory. What we do know is that more women diet than men and most weight management diets are unsuccessful in the long term, therefore, repeated failure is bound to have an impact upon a woman's psychological health and wellbeing. Part of the critique of the literature searched, is the lack of figures for emotional eating. We have no solid statistical evidence as to the different levels of emotional eating between men and women, maybe this is because comfort eating seems to be defined around women hence it is blind to men's eating patterns. The only study found is a dissertation abstract (Wood, 2000) where one of the topics explored was the effects of body weight and gender on levels of emotional eating behaviours. The findings were that "men reported significantly lower levels of emotional eating behaviors than women" and "men reported significantly less restrained eating behaviors than women" (Wood, 2000).

Certainly the research on comfort food selection seems to support women making comfort food selection in a differing way to men (Locher et al., 2005, Wansink & Sangerman, 2000 in; Locher et al., 2005, Steptoe et al., 1995). Steptoe et al. (1995) argues that women are more likely to make food choices based upon mood than men, and there seems to be a difference between the comfort eating patterns of men and women. Men are more likely to choose hot foods and main meals as their comfort foods while women choose sweets or snack foods. Women are more likely to cook entire meals for men as providing comfort, whilst men offer comfort by giving gifts of chocolate and sweets to women (Locher et.al., 2005, Wansink & Sangerman, 2000 in; Locher et al., 2005). One gender related theme that was prevalent in a study undertaken by Goodspeed Grant (2008) was around 'caretaking'. She found that every woman in the study and none of the men "reported putting others before themselves" (p.128). Lupton (1996) suggests that this has a great deal to do with masculinity and femininity. She argues that masculinity is associated with eating foods others have prepared and cooked for you, whereas femininity is associated with cooking for others and offering food as love (p.108-109).

Goodspeed Grant (2008) explored the emotional and social consequences to extreme obesity. She argued that we need to understand the broader social context in which individuals learn about and experience food to understand the current obesity phenomenon. She proposes that there is a missing link between scientific knowledge and individual behaviour, and that the "disease model may not be sufficient to understand all aspects of the problem" (p.122). Other approaches such as psychosomatic theories strongly suggest that emotional eating is highly prevalent in obese individuals (Ganley, 1989). However, Allison & Heshka (1992) suggest that emotional disorders are a result rather than the cause of obesity. This may link to what we do know, which is that in general; commercial interventions for obesity are targeted at women, who in turn are left searching for the perfect body. Culturally, diets, appetite suppressants, weight management programmes, surgical interventions etc., all physical approaches, result in women engaging in behaviours to achieve the perfect body. However, it is important to recognise that these behaviours, by women, are all linked to their psychology.

Let us now focus upon the emotional needs of women which give rise to overeating and using food as a form of comfort. From the literature, the concept that emotion strongly influences eating, and the fact that the terms, comfort eating, emotional eating and compulsive eating often overlap and at times seem interchangeable, this thesis will hereafter refer to these concepts as "emotional eating" within which the process of comfort eating may sit.

5. Emotional Eating and Women

Buckroyd (2011) puts forward that the abundance of food in the Western world leads us to use food however we choose; as such it becomes a symbolic representation of multiple meanings. She suggests that in all walks of society, food is used to mark developmental life events and celebrations such as weddings and, it is also used "to soothe and comfort us" (p.16) at times such as funerals. Buckroyd argues, we have established emotional uses for food, which we use as a coping mechanism, "the thing that will soothe and calm us or reward us" (p.16). She believes that some emotional use of food is normal but, when food becomes problematic we need to explore what emotional affect underlies this. We need to understand what drives us to use food as a solution to a problem. Emotional eating is seen by Bloom et al. (1994) as masking the pain that women experience about themselves. They see eating problems, as a way "women use their bodies to negotiate the socially created, psychological circumstances of their role" (p.xii). They believe emotional eating is a 'symptom'; the woman turns to food as she does not know how to cope with whatever lies beneath this behaviour.

Research suggests that many obese people eat as a result of meeting emotional needs, which at times can feel beyond their control (Chua et al., 2004, Gluck et al., 2004, Linde et al., 2004, Yacono Freeman & Gil, 2003, Yanovski, 2003). The feeling of being 'out of control', then leads to women eating a restricted diet or adopting "unusual, phobic obsessional behaviour around food" (Buckroyd, 2011, p.13). Bloom et al. (1994, p.xi) add, that emotional eating and going on a diet, seem so common in today's world that they are experienced as being normal by all, including the mental health professionals. They go on to say that the internal need and want that are manifest in emotional eating, and the subsequent restraint of that need, (dieting), are central tenants to all eating problems (ibid). Thus, body insecurity leads to dieting, then to bingeing or emotional eating and to further dieting. This endless cycle reflects the findings of Brownell (1988, p.22) in terms of "weight cycling" or "yo yo dieting". The dynamics of this endless cycle, Bloom et al. (1994) argue, applies to

an anorexic patient on the "verge of death", the ordinary woman who "diets several times a year" or to all that declare a need to diet so many times a day. They see no difference, as all these women are experiencing pain about themselves, their food and their bodies on a daily basis (ibid, p.xii).

> "Eating or restricting food without reference to hunger and satiation, berating oneself for eating and for needing to eat, being obsessively concerned about food, and devaluing one's body are the common characteristics of all eating problems" (ibid).

In summary, eating appears to be "simultaneously a physiological survival drive, a behaviour, a private emotional experience and a social phenomenon rife with symbolism that is embedded within the culture" (Goodspeed Grant, 2008, p. 124). The concept of emotional eating and obesity have received much attention (Kaplan & Kaplan, 1957, Slochower, 1987, Van Strien, 1994, Van Strien & Ouwens, 2003, Geliebter & Aversa, 2003 and Evers et al., 2010) all of these studies conclude that overeating by obese individuals is caused through eating in response to negative emotions. These conclusions are in agreement with the findings surrounding the consumption of 'comfort foods' by Dubé et al. (2005) Locher et al. (2005) and Le Bell et al. (2008). Two studies (Slochower, 1987, Van Strien & Ouwens, 2003) found emotional arousal led to excessive food intake, and overeating in this way also had an anxiety reducing function. High sugar, high fat comfort foods were found to reduce the influence of stress on the behaviours of rats (Dallman et al., 2005). Ganley (1989) argued that emotional eating is prevalent across social classes and differing levels of obesity, but, its prominence is more clearly established for obese women, and less consistent for obese men (p.357).

However, it must be remembered that some compulsive or emotional eaters are not obese and some obese people do not eat compulsively (Heenan, 2005). Therefore, what is it that makes us restrict our diet if we are not fat in the first place, and if emotional eating is not an eating disorder? Bloom et al. (1994) suggests that buried beneath the symptomatology of all disordered eating problems are the dynamics of emotional eating, which are; "a lack of entitlement about eating, prohibitions against

knowing and using internal physiological signals and an absence of internal structure that is self-soothing" (p.83).

Having established the clinical definitions and non-clinical considerations for disordered eating patterns, and looked at the role of emotional eating and women, have we got any better conceptualisation of emotional eating since Orbach's thesis? What we do know is that disordered eating is no longer only the prerogative of females. However, whilst the incidents of men with eating disorders are increasing, women are still in the majority and the commodification of the female body has resulted in women being an entity within marketing. How a woman looks is not a private matter, regulation of food links to a woman's identity which lies very much in the public domain, therefore society is very powerful in this domain and fat does indeed become a feminine issue. In a culture where a 'perfect' body symbolises more than just good health, maybe the perfect body is unattainable. The unrealistic goals projected onto women via marketing may result in body dissatisfaction, giving rise to the whole weight cycling circle starting over again (Brownell et al., 1986). Although studies exist to the effects of dieting, little attention has been paid to the *process* of why people continue this cycle. More research needs to exist on the process behind comparing oneself to the ideal, then falling short. Also the question stands of why we are failing to reduce obesity when all the evidence points to obesity leading to serious health issues.

Given the evidence of low research into emotional eating, with the most advancement in the area of eating disorders being in AN, BN and EDNOS, and more recently BED, clearly a more detailed exploration of the *process* that underlies 'emotional eating' and what drives people to eat for 'comfort' needs to be undertaken. This study therefore focuses upon what the discourses and underlying processes are for comfort eating. Such insight into this area would enable the area of emotional eating to be recognised within the *whole* area of disordered eating. By asking these questions this may result in practitioners being able to link research to practice in the context of the United Kingdom's obesity 'epidemic'.

Therefore, the aim of this study is to focus upon women, and address the clear void or gap that exists within the emotional eating section of disordered eating. In order to explore Susie Orbach's thesis of women's eating being connected with powerlessness, it seems fitting to use a methodology which is interested in social positioning and sees power as productive, a Foucouldian Discourse Analysis. From the questions raised in the literature search, the research questions that need to be asked are now clear and follow in the methodology section.

6. Methodology

6.1 Aims and Research Questions

The aim of this study was to analyse the discourses women use to describe their eating patterns in relation to comfort eating. The idea originated from the work of Susie Orbach (1978) which focussed upon women's eating patterns and 'fat' being rooted in powerlessness and self-denial. The research questions emerged firstly, out of an interest in Orbach's account of comfort eating, and whether such an account is, or is not, still relevant today. Secondly out of the scarcity of research around emotional eating, and finally, an interest in the language that women use, and how they use it to translate information about their identities that is, symbolic interactionism. The research questions which evolved were;

1. What discourses can be identified in women's description of their relationship to food?

2. Is, and if so in what way, emotional regulation acknowledged in these discourses?

3. Is comfort eating recognised in these discourses and how is it used?

6.2 Research Design

The research for this study consisted of two parts, Phase 1 and Phase 2, using two different methodologies. Phase 1 was a preliminary internet based collection of data, and phase 2 was in the form of semi-structured interviews. The rationale behind having two separate data collections was; phase 1, using Thematic Analysis (TA), to obtain an initial data set of themes related to the research questions, to guide and inform the direction of the semi-structured interview questions for phase 2. Phase 2 was a more in depth interview approach explaining these initial themes in more

detail. However, the journey towards finding a suitable methodology was not an easy one. At the beginning of my research, the department's supervisor retired, and as she was only committed to seeing through the students who were nearing completion, I was allocated a temporary supervisor. Subsequently, the University intermitted my studies for six months in order to reorganise the department and find permanent supervisors for the doctoral students. At this point I had completed phase 1 of the research and had designed the semi-structured interviews for phase 2. I was well advanced in the collection of the data for phase 2 and in discussion with my temporary supervisor it had been agreed to use Interpretive Phenomenological Analysis, (IPA) as a research methodology for my data.

I was now at the point where I needed some solid input into the research design and therefore decided to be pro-active and undertake a 4 day Masterclass in IPA at another University. It was after this intensive course that I became aware that IPA did not appear to be the best methodology for my research data as the interviews were of 20 minute duration. It was not until I was allocated a permanent supervisor, who validated the work that I had done so far and gave me solid input on other research designs, that I decided that IPA was indeed not the right research methodology. Therefore, after supervisory discussions and a compare and contrast exercise of differing approaches, a Foucauldian Discourse Analysis (FDA) was considered to be the best way forward and was the methodology used for the analysis of the data from phase 2.

Qualitative research mirrors and reflects reality (Harper, 2012, p.87). It works by exploring the content of particular individuals' beliefs and responses. The rationale behind using a qualitative approach was that it would produce an account which may contribute to the understanding of the processes which lead to using food for comfort. Qualitative research is commonly used to study a specific issue, in this case comfort eating, and it produces a clear unmediated representation of the object of study, whilst at the same time, through the construction of language, a sense of what lies within can be captured (Banister, 1994, p.2-3). Language determines the lines by which we divide up our experience, an interest in the effects of language and

discourse are of central importance to social constructionists (Burr, 1995). Therefore, as this research was interested in how participants use their language it is fitting to use this approach.

Social constructionism (SC) is a theoretical orientation underpinning the methodological approaches of Discourse Analysis; it considers how certain phenomena or forms of knowledge are achieved in interactions. SC focusses on how a subject sees a phenomenon rather than the phenomena itself (Harper, 2012, p.90). The social constructionist approach to social science research draws its influence from philosophy, sociology and linguistics. There is no one overarching feature which identifies a social constructionist approach to research, but it is widely accepted that any approach which has its foundations in one of the 4 following assumptions can be classed as coming from a social construction perspective;

1. "Critical stance towards taken for granted knowledge
2. Historical and cultural specificity
3. Knowledge is sustained by social processes
4. Knowledge and social action go together"

(Burr, 1995 p.3-5)

Social constructionism makes the assumption that the nature of the world can be revealed by observation, that is, what exists is what we perceive to exist, that the way we understand the world is historically and culturally specific which is dependent upon the social arrangements prevailing in that culture at that time. The assumptions lie in seeing people as constructing their knowledge of the world between them, in daily interactions in the course of social life, therefore, language is more than a way of expressing ourselves. Given this way of looking at social interaction, the world gets constructed through language, it allows shared versions of knowledge, therefore our truth (our way of understanding the world), is a product, a social process and interaction with others (ibid, p.4). Given that this research focussed upon symbolic interactionism, the SC approach helped to find the symbolic meaning that participants relied upon through their language constructions.

Social constructionism is a collection of theoretical perspectives and Discourse Analysis (DA) is an epistemological approach to doing social research. DA is an overarching term which covers a range of theoretical research practices, all of which take language as their focus but all of which differ depending upon what it is the researcher is looking for in a piece of text. DA is both subjective and interpretative and is a way of analysing qualitative research interview material. Therefore, for all the aforementioned reasons DA was the most fitting approach for this research.

One type of DA is Foucauldian Discourse Analysis (FDA). FDA is based on the works of French philosopher, Michael Foucault, and originated out of the exploration of the relationship between language and subjectivity. Fundamental to the work of Foucault, was his view that knowledge was historically and culturally specific (Foucault, 1972). From a Foucauldian point of view discourses at any one time, both, facilitate and limit, enable and constrain what can be said (Willig, 2001, p.107). FDA focusses upon the ways in which meaning is constructed through language and how this varies across contexts, and is concerned with the role of discourse in the process of power. Discourse can be seen as a set of statements which make available a certain way of seeing and being in the world. Within these statements, the discourse offers 'subject positions' (ibid) which have subjective experiences and in doing so are strongly implicated in the exercise of power (ibid). FDA also takes a historical perspective to explore the way discourses have changed over time, and shaped historical subjectivities (ibid). For Foucault, knowledge is power over others, the power to define others (Burr, 1995, p.64). FDA advocates the taking apart pieces of text (deconstruction) to see how they are constructed, to trace the development of present ways of understanding. It looks at how current truths have come to be constituted, to bring to the foreground prevailing discourses and to examine the identity and power implications within them (Burr, 1995, p.166) "to lay bare the discourses operating through it" (ibid, p.167). Foucault's methodology however, involved more than an analysis of texts; it was also concerned with governmentality (Willig, 2001). Therefore, an analysis of the discourse for this study was not from a pure FDA perspective, but often reflected through a Critical

Discourse Analysis, (CDA) lens, one which is close to FDA to examine the meanings in the research interviews.

Both FDA and CDA pay attention to the relationship between a discursive event and the social, political and cultural structures that "frame it" (Willig 2001, p.118). The identification of such discourses is largely an intuitive and interpretative process (ibid). Therefore, given the exploration in this study is around the underlying processes that drive emotional eating (rather than a subject's experience of emotional eating) hypothesised as being about powerlessness and out of control behaviour around food, a methodology which is based in discourse and power seemed to be apt. The approach of DA comes in many varieties and cannot be considered as one unique field of enquiry, it is therefore a difficult task to have more than broad guidelines as to how DA is performed. There are different types of validity and different ways of assessing validity for a discourse analysis, the focus is on the quality of the research (Willig, 2001, p.148). Quality was ensured by the appropriate procedures, in accordance with the methodologies for phase 1 and phase 2, which will be described later.

6.3 Phase 1

Phase 1 consisted of identifying statements of what comfort eating is, using a thematic analysis.

6.3.1 Inclusion Criteria

The preliminary data for phase 1 was gathered via the use of the Internet. The data was collected by using the search engine 'Google'. Firstly diet 'chat rooms' were identified, and then a key question was posed to generate responses. The types of diet 'chat rooms' selected was guided by the fact that various restrictions were in place on some Internet 'chat room' sites. Therefore, only open sites were accessed. The key question entered was, "do you use food to comfort yourself?" The response

from this resulted in specific answers becoming available in the form of statements. Secondly, the question was used as a search term put into 'Google'. A combination of key words; comfort eating, comfort foods, were also explored in this way. The second search led to the access of pre-existing texts and blogs from which themes from the statements were abstracted. All statements and replies to the question were collected.

6.3.2 Exclusion Criteria

Some 'chat rooms' needed the researcher to be a member of a weight management organisation in order to access the forums, while others involved payment in order to use the site. Therefore, these sites were excluded from the search.

6.3.3 Ethics

The use of the Internet for data collection was approved through the original research proposal to the Universities Ethics Committee. The Internet is worldwide and the data generated is in the public domain, therefore, this preliminary data gathering had no major ethical restrictions; however there are still ethical considerations associated with using the Internet for research. As a code of practice for the online researcher, widely accepted guidance suggests;

> You may freely analyse online information without consent if;
>
> It is official, publically archived
>
> No password is required for archive access
>
> No site policy prohibits it
>
> The topic is not highly sensitive
>
> (http://www.cc.gatech.edu/-asb/ethics)

The principal researcher also took into consideration the ethical principles around confidentiality and privacy by not using any identifying narrative and keeping the statements secure until the completion of the Doctor of Clinical Science Programme, at which time they will be destroyed. The data was collected in a manner that respected the online participant.

6.3.4 Procedure

The aim was to generate statements of what comfort eating is, and having identified over one hundred statements in answer to the question and key words, all statements were read and re-read. Out of the one hundred statements identified, sixty were deemed suitable for analysis. Forty were either duplicate or inappropriate responses. The responses were analysed using a Thematic Analysis (TA) (Braun & Clarke, 2006) to illustrate which themes were of importance for the phenomena under study (comfort eating). TA is similar to content analysis but is qualitative rather than quantitative in nature. TA offers the researcher an ability to not just analyse the frequency of the occurrence of particular categories and themes, but to look at the meanings underlying the phenomena (Joffe, 2012). A theme refers to a "specific pattern of meaning found in the data" (ibid, p.209). The themes identified were both manifest (observable content), and latent (implicit content). Because TA is not tied to a particular theoretical approach it can be applied to a range of epistemological approaches, including the DA approach of this study. The preliminary data set traced how a given group conceptualised the particular phenomena of comfort eating, building a credible map for exploration, grounding the data and giving direction in order to further deepen the train of enquiry with phase 2 of the research analysis.

6.3.5 Data Analysis

After initial readings of the statements, a coding framework was created as a tool to identify themes. The framework consisted of the code name, definition of the code and an example of the types of data that would appear under this coding name.

6.3.6 Quality Control

The two different methodologies have two different approaches in terms of validity and quality. As the methodology used in the initial phase of data collection was a TA, the coding frame could be checked for reliability and validity (Joffe, 2012). This was done with the assistance of an independent coder. The principal researcher sat with a fellow research student and presented the coding of the text, from this the coding was modified in collaboration in order to be more exact. Consensus was reached through an audit, thus developing a more reliable and valid coding frame.

6.4 Phase 2

6.4.1 Participant Inclusion Criteria

The focus of the research was women who already had a concern about their weight, therefore, it seemed sensible to approach a group already established for issues around weight control. Slimming World (SW), a United Kingdom, (UK) based weight loss organisation was a suitable organisation. It holds over 9,500 groups around the UK and was established over 40 years ago. It currently estimates having over 400,000 members (www.slimmingworld.com). Ethically, it was also considered appropriate to approach a group that had a 'gatekeeper', therefore, a local SW group was approached and permission was gained from the 'gate keeper' to address the group with regard to inviting volunteers to participate in this study. The inclusion criteria were women over 18 years of age with no upper limit, English speaking, literate and with an ability to give informed consent. The group was addressed by the researcher, and given an open invitation to take part in a semi-structured interview.

6.4.2 Ethics

Ethical approval was sought and obtained from the Universities Ethics Committee, (see appendix 1). No vulnerable groups were involved and all participants had a capacity for consent in accordance with the Mental Capacity Act, 2005. Confidentiality of information and anonymity of participants was respected. Each participant was informed of their right to withdraw from the interviews and study at any time without explanation or fore warning, for whatever reason. As the topic of this study could be an issue of some sensitivity, an empathic response to the narrative and participants' well-being was of paramount importance at all times.

6.4.3 Procedure

The SW group was a mixed gender group, however, due to the inclusion criteria for this study, a participant information sheet, (see appendix 2), was given to those who met the inclusion criteria (60 members on that particular evening). Informed consent forms, (see appendix 3), were provided and signed by those taking part in the study which contained full information on the purpose of the research, the method of data collection and what the participant's involvement entailed. Out of the group of 60 members that were invited to take part, 26 participants gave signed consent, 2 dropped out and 24 semi-structured interviews took place.

From the initial phase 1 data, categories and themes were turned into 9 open questions which formed the basis of a semi-structured interview, (see appendix 4). There were 24 interviews arranged, each in the participants own home, or agreed place of meeting, at a pre-arranged appointment time. It was considered firstly that interviews 1 and 2 were pilot interviews on which the researcher reflected whether the correct questions were being asked. The interviews and questions appeared to be appropriate, therefore the process continued. Each interview was conducted with the use of an audio tape machine. Time was taken over the setting up of the interview, explanation, and signing of the consent form, this was in order to facilitate as relaxed an atmosphere as possible. The questions were asked in the same order

to each participant and punctuated with minimal prompts ('a hum, mm, because...? as in?' etc.) to aid exploration and gain clarity. The last word spoken or a significant theme was also reflected at times to further the researcher's understanding. Given how difficult it is to define and measure comfort eating, the purpose of the semi-structured interviews was to yield qualitative information on factors affecting and influencing a participant's relationship to food through the discourse. Each interview was short, approximately 20 minutes in duration, but the data provided was rich. Each participant was personally thanked for their participation.

The audio tape recordings were then transcribed and the original tapes were stored in a locked safe until the completion of the Doctor of Clinical Science Programme. The data set from phase 2 was analysed using a Discourse Analysis in order to gain an understanding of how ordinary people construct 'meaning' and power to the topic of comfort eating.

6.4.4 Data Analysis

Discourse Analysis is a lengthy, time consuming and intensive activity, each interview was read and then re-read several times, each time searching for recurrent themes and coherent sets of statements or phrases which talk about events in similar ways. The text was analysed for metaphors which bring out images and for words loaded with meaning. Burr (1995) recommends analysis is aided by underlining words and phrases which 'paint a picture', then listing them on a sheet and scanning for any sense of coherence, for the researcher to ask, what images the metaphors bring. The analysis of the texts also looked for contradictions and what images or descriptions of events were being repressed.

In order to have a framework or set of rules to provide some quality, the data from phase 2 was analysed following the 6 stages recommended by Carla Willig (2001) for the analysis of discourses. Her recommendations aid the mapping of the

discursive resources in the text and the subject positions in order to explore the implications for subjectivity and practice (ibid).

Stage 1 – Discursive Constructions

Stage 2 – Discourses

Stage 3 – Action Orientation

Stage 4 – Positioning

Stage 5 – Practice

Stage 6 – Subjectivity

Willig (2001, p. 110-111).

Stage 1, discursive constructions, this stage consisted of identifying within the texts, the different ways in which the discursive objects, (DO), were constructed through the language in the text by the subject. That is, the ways in which meaning around comfort eating and the process behind comfort eating is spoken of. All references to the DO whether implicit or explicit, or constructions with shared meaning were coded. The texts were also analysed for the lack of direct reference to a DO by the participant, but the use of discourses around the DO.

Stage 2, discourses, entailed identifying all sections of the text which referred to the construction of the DO and looking at how the DO's were constructed in differing ways. This is in order to locate the construction of the object within wider discourses (Willig, 2001).

Stage 3, action orientation, this stage enabled a closer look at the context within which the differing constructions of the DO are made. This was in order to see what is gained by the participant constructing an object in this way, and to look at the

function for the participant, in other words how does the DO construction relate to the surrounding text. Willig (ibid) purports that this stage helps us gain a clear understanding of what the various constructions of the DO can achieve within the text (p.110).

Stage 4, positioning, after identifying the various constructions of the DO and locating them within wider discourses the text is analysed to ascertain the positioning of the participant. A participant's position offers a way in which meaning is constructed for that participant, from a position within the discourse, giving direct subjectivity.

Stage 5, practice, the next stage entailed examining the texts looking for the relationship between discourse and practice, whether the participant enables the discourse to open up, or close down opportunities for action. The participant positions and their constructions of their world being evidenced in a particular way within the discourse can limit or open up what can be said or done.

Stage 6, subjectivity, following on from stage 5, the final stage explored the relationship between the discourse and subjectivity. Willig (ibid) identifies this as the most speculative stage which attempt to make links between discursive constructions and the participant's experience. The discourses within the data showed how the participant made sense of, and had certain ways of looking at, the world, and certain ways of being. Therefore, this stage looked at what the consequences were for the participant in taking up these various positions. Stage 6 looked at the participant's subjective experience.

If Stage 5 can been seen as what the participant is saying and doing from within the discourse, Stage 6, explored what can be felt, thought and experienced from within the participant's position (Willig, 2001). The analysis of the discourse undertook an

examination of the language in terms of constructions and functions and how these form social action (Georgaca & Avdi, 2012, p.147).

6.4.5 Quality Control

The epistemological underpinnings and procedures of qualitative research paradigms are different to quantitative studies. Validity is measured in differing ways, for discourse analysis, it is more a sense of resonance, of meaning and significance, a richness and quality that is looked for. My reading of the text is obviously subjective and intuitive, it does not follow a set of rules and therefore ontologically it is not appropriate to be checked for reliability, but a better approach is to consider dimensions of quality. According to this ontological approach, there are acceptable ways of assessing the quality. Therefore, from the ontological position of SC, the generalizability and quality of a reading of text, places the reader in the position of an interpretive tool, thereby, within a SC framework my reading is one of many possibilities all equally valid (Burr, 1995, p.171). The question is not how truthful is this account, but how useful it may be in understanding, and perhaps eventually doing something about a certain issue (ibid) in this case, obesity.

There are various accepted ways to test the quality of a DA. The main core principles are to show 'transparency' and 'systematicity' of the research process (Meyrick, 2006) along with trustworthiness of the study (Williams & Morrow, 2009). 'Transparency' was established by sufficient detail being included in the study with regards to the journey taken from data collection to conclusion. This 'transparency' will "confirm that the researcher's decisions were reasonable" (Meyrick, 2006, p.806). The establishment of 'systematicity' was achieved by demonstrating that an explicit and consistent analytic framework and procedure were applied to the data (ibid). In order to ensure 'trustworthiness' in this study, three main categories were explored;

a. Integrity of data
b. Balance between reflexivity and subjectivity

c. Clear communications of findings

(Williams & Morrow, 2009)

Firstly, a point was reached whereby no new information could be gained from further analysing additional data, that is, 'redundancy' (ibid) was reached, thus establishing integrity of the data. Secondly, it is clear that the reflexivity, the engagement and participation of the researcher in the research, must not be overlooked. The research interview consists of moves and interaction between both parties and my role in the process and production of gathering a piece of discourse must be acknowledged. Therefore, my position as a female, psychoanalytic psychotherapist and the effect of this on the interviews was taken into account. My biases and perceptions were also explored through reflexivity and remaining reflective throughout the process. A reflective journal was kept and an awareness of psychotherapeutic phenomena such as my counter-transference, both subjective and objective was noted. This process led to an awareness of the difference between my own interpretations and the participants' meaning. Supervision also allowed assumptions and interpretations on my part to be challenged. Finally the findings were presented clearly and all interpretations were supported by extracts of each participant's text, thereby illustrating the meaning for the participants in the context of their lives.

The reading of the discourses were not discussed with the participants, therefore reflexivity did not include "respondent validation" (Silverman, 2010 p.278). Although this process is advised as a form of checking quality by Potter & Wetherell (1987) a counter argument by Parker & Burman (1993) puts forward that to do this may not escape the problem of power relations between researcher and participant. In fact, Marks (1993) found that despite her attempts to include the participant as part of her reflexivity, it was her own reading that carried more 'weight' than the participants. The quality assurances that were put in place on this study did result in an awareness of how my perspective and position have shaped the research, and how the participants have responded to my questions and reflections. This will be further

commented upon in the discussion section of the results. The reflexivity helped to scrutinize and validate the whole process.

7. Findings

7.1 Phase 1

Out of the sixty statements analysed, all respondents acknowledged having engaged in eating for comfort. The coded data was categorised into groups, an example of the groups that emerged were; food types (split in to sweet and savoury), references to people and family, implicit mentions, (generic and latent mentions). The findings from Phase 1 influenced and shaped areas of questioning for the semi structured interviews of Phase 2.

7.2 Phase 2

The data from Phase 2 was analysed using Discourse Analysis. All names and identifying narrative have been omitted and replaced by pseudonyms. Dots represent missing portions of the text which may otherwise have been identifiable. Participant's narratives are identified by the prefix 'P' followed by the transcript number, and the interviewer's narrative is prefixed by 'I'.

There were seven superordinate discourses found;

1. Genetic
2. Drive
3. Lack of control
4. Treating 'self'
5. Battle of Will
6. Lack of Self-efficacy
7. Public vs. Private image

7.2.1 Genetic discourse

The genetic discourse was a little distinct from others; however, this will be further discussed at the end of this section after all the discourses have been described. The genetic discourse clearly originated from a biological narrative;

P. "my mum always had a weight problem, so we was brought up with my mum never taking her, you know, never being able to go out in the summer unless she had a duster coat on because she was so fat, and my sister was very thin and I was very thin up till I had my son and I went from eight and half stone to twelve stone and then I've been fighting it ever since to be honest. I get thin and then some catastrophe will happen and I'll, I just can't stop eating then". (P.15).

Here the discourse of P.15, clearly reflects a belief in a genetic component following in the mother's pattern of having children and then gaining weight. It was a fore gone conclusion, genetically engineered, that this trait was inherited, automatically with no doubt. However, the discourse does reflect some recognition of the inability to stop eating, and the need to 'fight' when an external event or sudden great disaster occurs. Therefore, this discourse suggests a positioning of biological vulnerability, that is, there is an awareness that some agency remains. P.16 below shows how control is taken in order to gain some agency against the genetic 'trait' to gain weight;

P. "I've always watched my weight since I was 16 and my mum realised I was a size 16 and it was no longer puppy fat, and she said ooooh, I think you ought to watch your weight, cause my dad's side of the family were very big, I've got a cousin whose about a size 24, ummm, and I've always watched it .." (P.16).

Genetic discourses also discussed participants actually being born having a predisposition to put on weight;

> P. "I was born and I put on weight, I was an average sized baby but, I put on weight right from a very early age when I was a toddler, I've never ever been thin and so I've always found it hard". (P.6).

Again, there is almost a resigned factor about 'this is the way it is', reflected in P.6's narrative, however, in contrast to the two previous genetic discourses where agency was shown, the discourse of P.6 reflects no agency. It would appear from the genetic discourses that there are two positions, one that show a vulnerability which allows for some agency, and the second which is to be born this way, with no agency at all.

However, although only one participant reported that the full explanation for their weight gain was as a result of a genetic component with no agency, there was a clear belief in other participants that part of their weight gain was due to a component of some description, which was described in the sub text as an automatic 'urge' to overeat; a drive.

7.2.2 Drive discourse

This 'urge' to eat was described by many participants in response to external events, an almost instant need for gratification. The non-tangible and indescribable theme of this discourse ran through nearly all participants' narratives in one form or another;

> P. "I just needed it, I needed something". (P.1).

All participants reported that 'something' over took them in response to external events; some participants described a difficulty in defining what that 'something' was;

P. "I don't know if that is very easy and conscious to say, that that is how I justify what I do, but I don't know how true that is though, I am aware that I am doing it so you think that it is conscious, but there must be something else it's substituting, but what that something else is is very hard to locate, I think, I think it is something that doesn't exist it's not something material it is something else". (P.24).

Clearly the discourse questions food substituting 'something', but what that 'something' is participants could not quite locate. P.24 clearly states it is "not something material"; this discourse is an inexplicable and indefinable emotional response. The drive discourse seemed to be all consuming resulting in some participants reporting that to eat in order to live, for a real biological reason was their last consideration, and that unlike others, they lived to eat;

I. "Could you please tell me what food means to you

P. comfort (laughs)

I. comfort…

P. I think so and also and also I've always thought that some people eat to live where some people live to eat and I think I fall into the latter category". (P.15).

Food was clearly positioned as not only having a biological element but used as something all encompassing, as P.21 states here;

P. "every day I suppose revolves around food, my life revolves around food, that's why I'm the size that I am [laughs]". (P.21).

Discourse around an automatic, emotional response that resulted in overeating, ran through the following discourse of 'Lack of Control'.

7.2.3 Lack of control discourse

Lack of control can be thought about in terms of being trapped by something that is either confining or an undesirable circumstance from which escape or relief is difficult. The participants' discourse throughout, reflected a sense of powerlessness and lack of ability to exert any control over external circumstances. The narrative was defeatist in that; there was nothing they could do about the imposed conditions which resulted in them 'needing' to over eat;

P. "but I've had my parents living with me for the last 3 weeks,

I. ahmm

P. and um it it's going fine, she's making a real effort, but it's like we're walking on....

I. yes

P. it's like walking on eggshells all the time and do you know I've put on weight and today I bought a cake, can you believe it, I bought a cake and I ate it!" (P.1).

The external condition imposed that P.1 describes, is one of having parents living with them and reflects a lack of control and being trapped in the situation. There are two clear positions, one of everything being "fine", and the second discourse around emotional affect and heightened sensitivity. P.1 expresses "walking on egg shells"

and tip toeing around her mother resulting in a stressful situation which culminates in the purchase of a "cake". It is interesting to note that P.1 does not specify a link between her parents staying and the buying of the cake, she knows however, that in some way they are connected, hence she links them together in the same chain of events. She does however, sound surprised that she bought and 'ate' the cake. There is clearly an inexplicable missing link, which again reflects the inability of participants to put into words what it is that takes over them, the non-tangible missing link. However, within this 'lack of control' discourse, some participants do describe a recognised link between eating behaviours and external uncontrollable events impinging;

P. "um, at the moment I am not dieting, because I um, my husband is ill and I've had people to stay and, we are supposed to be going away next week, we had to cancel last week, I think we might have to cancel next week..... so there is a fair amount of stress around and I am trying to get him to eat which has been very difficult and so that all that sort of thing, I just haven't got the emotional input to look after my own diet, so I have totally stopped. And then I don't feel guilty, I just eat what I like." (P.4).

Within this discourse, participants presented a justification for their inability to diet or lose weight on numerous occasions, as with P.4 above, reporting the lack of control over the external events to justify her decision to stop dieting. P.4 subsequently reports being emotionally drained with no energy to control her eating and defaults to overeating. This discourse reflected that participants seemed to need clear space and time in order to put their dietary needs first and this could not occur if they felt out of control. Discourse around feeling trapped until such times when a clear 'space' occurs, leads to participants feeling they do not have the individual agency to take control over the external event, resulting in the 'lack of control', P.4 goes on;

P. "when these trips are over, if we go at all, and after I have got some more people relations coming from Australia, when they've gone, I've got two clear

months and with nobody coming to stay and with us not going away and I shall diet in those two months so I can control, but, I mean it is a bind because I put weight on and then I lose it". (P.4).

Here clearly, the element of being trapped is reflected in the use of the word "bind", reflecting a discourse of being tied tightly into something that is beyond the participant's control.

Another layer of lack of control was seen in the perceived lack of choice that participants had in relation to societal norms. This underlying discourse seemed to reflect an inability to take the power resulting in the discourse being one of inevitability;

P. "Yea, if you go out it's nice, yes definitely it's a social isn't it, I thought that yes, cause you go out, you go in a pub and you don't just want to drink, you've got to have a meal haven't you, yea and if I'm out shopping I have to have a coffee and then I have to have something to eat, just a little, you know scone or something, good, yea yea pleasure and comfort and socially, yea".

I. So would you say you comfort eat?

P. I do sometimes yea, and also well, I suppose this is the same, it's not just if you feel a bit fed up or down you eat, I eat sometimes I think it's cold, I think, oh have a coffee and a few biscuits, it's a yea if it's cold so it's yea I do comfort eat.

I. So if it's cold, what does that mean for you?

P. have a nice warm coffee and I love dunking biscuits especially chocolate ones [laughs collaboratively]". (P.9).

This construction reflects a positioning around the normality of what we all do in society, it is what is expected of us, there is no power or choice in this position, the power is external to the participants, society controls how we behave. P.9 is seen here as using a controlling narrative "you've got to", and "I have to have", all reflecting no choice, no control and no individual agency.

Within the 'lack of control' discourse, participants also reported medical reasons to explain their eating. The causal chain of events was diametrically opposed to the genetic discourses, whereby participants perceived themselves as being born with a predisposition to weight gain. In this discourse participants reported feeling in control of their eating with very little problem, then as a consequence of some external event, in this case a medical reason, there was a break in the participant's control. The discourses of lack of control positioned the causality in differing ways. One of these constructions was around pregnancy being the reason for weight gain and participants not being able to reach their pre pregnancy weight;

> P. "I put the weight back on because I got pregnant, or partially because I got pregnant, I use it as an excuse really". (P.22).

However, as with P.22 there was often an acknowledgement within this discourse that participants were aware on one level that they were using medical reasons as an excuse for their weight gain. Participants often used a discourse of 'justification' for their overeating and being controlled by food and emotion. This 'justification' was found in the discourses around being trapped by their medical conditions;

> P. "it wasn't the fact of what I was putting into my body that made me put the weight on in the first place, it may well be that it was the injection affected my mood and my appetite which meant that I eat more, but if I was eating the right foods it wouldn't have had such a detrimental effect." (P.22).

Constructions around medication being a cause of weight gain further layered the discourses reflecting participants reporting a lack of control. Here P.22 is seen as having no control, leaving her feeling powerless over the effects of this injection. There is some realisation that she could have taken control if she had the individual agency to eat the "right foods", however, she positions herself as being unable to do this, again reflecting the missing link or, non-tangible phenomena that is inexplicable, whereby participants are unable to find the agency to take control of their eating.

Loss was also associated with this discourse about lack of control, often through an intermediary connection. In describing the aftermath of the loss of her mother, P.7 links the loss to her uncontrolled eating, mediated by the direct link with taking anti-depressant pills;

> P. "for the last year I've been on an anti-depressant so I'd gone from like my normal eat when I was hungry whatever, to not eating at all and you can imagine like you just lose loads of weight, you feel shit all the time to then when I took them pills they made me eat and I wasn't hungry in my head I wasn't hungry but just kept scoffing, it was mad, I was eating cakes I don't even eat cakes I don't eat chocolate it don't do nothing for me at all hence I put on a stone and a half through them pills, [collaborative laughter]". (P.7).

Here we see a clear link with a normal biological hunger response which was controlled, to the lack of control discourse of "them pills they made me eat", caused by loss and grief. This participant appears to have no idea why the consequence of grief resulted in a lack of control over her eating. P.7 reports that the chocolate, "don't do nothing for me", this is a double negative so maybe on one level, this discourse could be interpreted as a psychoanalytic example of causality being out of her conscious awareness. The food she was now eating was doing something for her, but she is unable to recognise this.

Finally, within this discourse around lack of control and feelings of being trapped, many participants used language that related their behaviour to that of an addict being trapped in addictive type behaviour. Just as an addict would hide away a drug, participants were found to 'hide' the foods that were of importance to them as if they were valuable possessions. The excessive desire for these foods culminated in narrative using words such as my "stash" (P.14) needing "a fix" (ibid) and likening excessive consumption of foods to that of going "on a bender" (P.15). Participants reported the only way to control the need for these types of foods was not to have them in the house;

> P. "it gives you that bit of a high doesn't it, I try to buy things I don't like so I don't eat them". (P.20).

The lack of control discourse reflected participants having great difficulty in keeping these comfort type foods in the house, one participant resorted to keeping chocolate "hidden in the freezer" (P.14) in order for it not to be easily accessible. Participants reflected a tension between being able to resist the "stash" or "fix" (P.14) in the cupboard or freezer, and wanting to have their needs met, rather like an addiction. There was a dichotomy constructed between participants wanting the enjoyment of the foods, whilst at the same time knowing they were exhibiting out of control behaviour. Many participants reported food as having an addictive element that overpowers them, resulting in a lack of control;

> P. "I think being overweight and having a weight problem is as bad as being an alcoholic or even a drug addict, [laughs], because I think we can't, can't help ourselves". (P.15).

Most participants kept themselves trapped in the 'lack of control' position stating that there were other external reasons for their eating; it was not their fault that this was happening to them. They linked events out of their control as being implicated in

their overeating, some acknowledged a clear causal link, but others did not and find the link 'inexplicable'. Paradoxically, could it be that they were actually keeping themselves in a place of control and power by not taking any responsibility? Let us now look at the discourse that emerged from participants who tried to take some control.

7.2.4 Treating 'self' Discourse

As a way of trying to take control of their eating, other participants turned to food. They used food as a way of treating themselves in an attempt to alleviate stress or emotional distress. The discourses around treating the 'self' positioned the participants in two distinct ways. The accounts of the meaning of food and eating for comfort were constructed as either (i) something deserving or relaxing or (ii) an activity which is secret. All participants positioned themselves as alone whilst engaging in eating behaviours that were rewarding or treating, however for some, the element of secrecy was pronounced.

Within this discourse, we see differing uses of the term 'treat'. Firstly, food seemed to either represent a reward for participants who have been 'good' with regard to their dieting habits;

I. "Can you tell me what does food means to you?

P. Umm, sustenance, errm sometimes pleasure, errm also sometimes I think a sense of reward because you might think, yesterday I've been good, I'm going to have this today". (P.11).

And secondly, food was seen as something that made participants *feel* 'good' as in;

P. "It made me feel good, the chocolate made me feel good, made me feel a bit more relaxed". (P.8).

Clearly, in the two examples above, the act of being 'good' in terms of their eating, "yesterday I've been good" (P.11) was not intrinsically rewarding enough in itself, therefore this resulted in participants needing to use food in order to feel "good" (P.8). 'Treat' was presented in two further ways, participants' narratives were constructed around needing a 'treat' immediately, as a reward, but it was also used to 'treat', to make participants feel better;

P. "it's immediate isn't it, you could pick up food, but any other treat you could pick up, like a magazine or, or even a hug, or, or, you've got to go and sort that out, but food you can always get your hands on food

I. instant

P. yes, yes

I. so there is something in you that occasionally gets to the point where you instantly need that treat

P. Oh, yea, you and get the lid off the biscuit barrel really quick [laughs], someone should tape it down! [laughing]. (P.3).

Here we see that 'treat' is constructed around a discourse of taking control and providing for 'self', positioning P.3 as needing something to treat herself instantly. Often participants' narratives reflected them taking some control by way of a treat. Here, by freeing herself from not having to ask or "sort" something out, P.3 takes control and treats herself with the biscuits. However, other participants described their comfort eating as having more of a 'treating' usage, almost as a self-medication;

I. "What is this 'fed up', what triggers it?

P. mainly just being either upset or stressed out, if I'm stressed I eat, I mean a lot of people if they are upset or stressed they don't eat, or they can't eat but I'm the other way, I would say that I comfort eat a lot which isn't good [laughs]". (P.20).

This discourse showed many participants positioning themselves as being different to others who were perceived to not eat when they are distressed, which is a clear difference to participants' constructions reported here around eating out of disruption or distress. The sincerity overeating to 'treat' one 'self' is reflected not as a frivolous eating, but an eating to ease the pain. Many discourses referred to 'treating' themselves with reference to foods having a biological or medical function almost as a justification for their eating again;

I. what do you feel when you are eating it [chocolate]

P. "just feels, I don't know, feels a relief, sort of oooh, cause it's got like, it's got like endorphins or something in it hasn't it, so it type of releases that, and it's type of makes me less stressed, some people like to have a drink at the end of a stressful day, me I like to have some chocolate". (P.14).

Here we see a clear construction of food being used as a relief, to ease, remove or reduce pain, anxiety or stress; to self soothe. Food was used in this discourse to self soothe in various ways satisfying a variety of emotions. Here, after constructing a narrative around how she comforts herself with food, P.24 reports that food means everything to her; she uses food to treat her 'self' in all ways;

P. "treat myself, congratulate myself, console myself". (P.24).

P.24 is a clear example of the discourse of 'treating' being constructed from differing positions, one taking pleasure and comfort in food, "treat myself, congratulate myself", and the other as a medication to relieve symptoms, "console myself" (P.24). Whether the emotion reflected by participants in this discourse was negative or positive the position adopted was to gain back the power and take control with food. The discourse around giving oneself a treat, was part of a cycle of events which frequently resulted in the punishment of 'self' subsequently to having the treat. This cycle was often reported as unyielding;

P. "if I've come home from work and pigged out, I would probably not have dinner, so I'd think, I've had all that then I won't eat dinner now,

I. so you almost punish yourself by not eating?

P. yea, yes, not eating yes, I'll have a bag of crisps, packet of biscuits and you know, a bar of chocolate when I've got in from work, so I think I'll skip dinner and then, and I know that's not the way to do it, but I think sometimes, I think, if I don't have dinner then perhaps what I would have eaten for dinner won't go on as well as what I've eaten when I've got in from work, so it is a, I know I do it, and I've done it for a long time, but I can't seem to break the cycle of doing it". (P.20).

The above discourse reflects a trap, similar to the previous 'out of control' discourse, but here we see a series of events regularly repeating and perpetuating a process, resulting in a restrictive deprivation. A sub text in the treating 'self' discourse seems to be an instant gratification which ultimately led to the punishment type behaviour whilst participants were trying to take back the control and power;

P. "cause I think half the time I've shovelled it down before I've even realised I'm doing it, [laughs], I think if you thought about it and I thought, oh right I'll go and do something else and take your mind off, it would probably, but I think it's a sort of, ooh what can I eat when I get in". (P.20).

Here we see P.20 reporting engaging in the "shovelled" down food as quickly as possible, whereby eating became almost an anonymous action. The treating discourse often reflected an inability of participants to make sense of what happens in the times when eating seemed to be out of their conscious awareness, similar to the lack of causal links demonstrated in the 'lack of control' and 'drive' discourses. Constructions around the position of having difficulty understanding this emotional response to eating were evident in this participant's narrative;

> P. "Errm, I suppose I sit and think too much and then sort of eat, it triggers the fact that I feel hungry, I don't know really, what, what the problem is, you know". (P.13).

Although P.13 reports that she does not know what the "problem" is, she positions comfort eating as the solution to the problem. This discourse again reflects how hard it seems to break and resolve a cycle of events which lead to comfort eating. Within this discourse, food and comfort eating were used as an emotional crutch;

> P. "I relied on it, it was more sort of comfort food, and especially after me husband died, I mean most people lose weight [laughs], I didn't I put it on [laughs], so I sort of you know just picked". (P.13).

The discourse reflected here, shows a relieving of some 'dis-comfort', it demonstrates how participants carefully chose, "picked", out foods to relieve the emotional discomfort. Another common factor throughout this discourse was the use of laughter, as with P.13, to distance the participants from feelings around the painful discourse.

Another layer of the treating discourse, reflected participants using food as a comfort to replace something, this included replacing a significant other. When using food as

a treat to make up for and replace the presence of another, P.21 reports eating worthless matter, "rubbish, chocolate, crisps, cheese, crackers, all the wrong things", (P.21) when alone;

P. "If I'm on my own it will be all day I'll pick and I'll think, oh I'll have that and I'll have that, I'll have one of them, oh, that won't matter, but if I'm out with mum or at mum's house, because she doesn't do it, I won't do it, so if I'm out for the day all day, I'm completely fine, it's when I'm in on my own or I think, when normally I'm on the go and I think, oh I'll do this or I'll do that, as soon as I sit down I think oommm, what shall I have

I. what is it you feel when you're in on your own

P. It's loneliness, so rather than think oh well I'll have something to eat properly, especially when he's asleep, [baby], when he's asleep I think, oh I'll have a nibble." (P.21).

The discourse of treating 'self' often reflected how participants saw themselves, or felt others saw them. The significance of choosing this worthless matter, "rubbish" (P.21) seemed to reflect how participants often felt 'rubbish' with a clear sense of not quite being 'good enough' (Winnicott, 1990). Maybe, on an analytic level, the food replaced the significant other, and participants internalised something to try and fill the space themselves. This may have resulted in participants being left with a sense of not feeling they were worth being with? What is clear in this discourse is that many participants used the term, "pick"[ing] (P.21) this discourse shows how participants actually carefully chose and rewarded the 'self' with these types of comfort foods in the absence of another. P.23 gives another clear example of the discourse of treating 'self' being constructed when participants are alone;

P. "I'd say really it's because when Jim's here I don't eat, because I know I'm not supposed to, but when he's gone to bed, he's not here, and I think ooh, I'll just have a few of them nuts, or I'll just have a bit of that fruit

I. so it's more a secret

P. yes, yes in, in, but it's only in the evening, why I don't know only in the evening

I. does it not happen at all during the day?

P. no, no, just in the evenings, I do wonder sometimes whether I think, oh he's gone to bed, you know a bit of, I don't know what you'd call it, a bit of errm, annoyance, [quiet accentuated voice], so I'll eat that instead, I think that it is comfort food as in somebody with me, but it's food with me rather than, not like him sitting there

I. so he goes off to bed and something makes you annoyed

P. yea, cause he's gone to bed I'll, yea, yea [laughs], bit annoyed with him and I'll have that instead and that's it, yea, oh he's out of the way and I'll eat something

I. so is it quite instant, like you need it now

P. Errm, more or less, I can hear him get in bed and then I think, mmmm, I'd just have a couple or three nuts, and I sit there [points] go to Jim's chair and eat them I don't bring them over here, I sit in his chair". (P.23).

This discourse often reflected participants positioning themselves as being 'good' in front of others as if they are in control, as opposed to the defeated discourse position of "I'm not supposed to" (P.23) which is rather childlike. This discourse constructs a position of power when eating out of the view of others and P.23 clearly reflects some anger or resentment at being left alone, she rebels against what is expected of her, what she feels she 'should' do and food becomes a symbolism of that power. We see P.23 taking control by taking the seat of power, both metaphorically and physically. By sitting in "Jim's chair" she becomes triumphant.

There is a childlike 'naughty' behaviour often layered in the treat discourse. The participants often reflected a childlike discourse, although demonstrating a clear potential for self-agency, this agency appeared not to be adult appropriate. The childlike behaviour will be considered in the discussion section later, however the conspiratorial aspects of the childlike behaviour can be seen in the following example of treating 'self' discourse;

P. "when the kids have gone to bed I'll make a nice hot cup of tea and I'll sit in the living room and see what's on tele and then I'll think, ooh, I've got some chocolate in the freezer and I'll have some chocolate, and it's always when the kids have gone to bed [laughs], so it's always at the end of a, the stressful day, and I'll just have some chocolate [pronounced exaggerated in a whisper]". (P.14).

This discourse of eating whilst alone sets up the construction of a sub discourse in treating 'self' which was pronounced; one of secret eating;

P. "it could be anything, it could be five sandwiches, it could be err, Easter Egg that I've bought in secret, it could be err

I. is there lots of secret eating?

P. yea, [very quiet whisper], yea, there is a lot of secret eating, it's weird cause, I always own up to it eventually, but not necessarily in the same hour, same day, same week, but secret eating definitely goes on, and is usually when I'm feeling shit that secret eating goes on, as opposed to when I'm celebrating and happy and I just share it with everybody". (P.24).

In this example, two types of eating are mentioned, one celebratory and one secret associated with negative feelings, and hidden away. The urgency around the discourse of overeating and the need to treat 'self' is reflected clearly in secret

eating, the onus is on a 'need' that overwhelms the participants, fulfilling an emotional need in a position away from others;

P. "yea, cause I sat and ate the cake in the car, um after I came out of ..... cause I knew if I came home I wouldn't eat it cause they, [parents], are there, I needed it though

I. you needed it then and there

P. yea and I *did* need it too !". (P.1).

Clearly P.1 states that if she had gone home, the cake would not have been consumed in front of others. Within this discourse, food was often positioned on the one hand as something to be shared, something collective, and on the other something secret that was not shared;

P. "I think it seems to be that I want to eat something before Brian comes home, while I am still on my own, so it's a secret thing isn't it, just for me, and I look at the time and I think ooow, well I can have a biscuit before he comes in biscuits are a bugger aren't they, (is it alright to swear on there) [laughs and points to the tape recorder], and I think oh, Brian will be home from work soon so I could quickly put some butter inside some biscuits, don't know what that's about". (P.3).

By both rewarding and treating of the 'self', the discourse reflects a paradox of needing to give something to 'self' and take control or power, whilst at the same time reflecting an eating pattern that was at times out of control, resulting in participants feeling powerless. The discourses in this section also reflected something of a need to take back something for the 'self';

I. "so can you tell me what that feels like, when they have gone to bed and you have your chocolate?

P. naughty, just for me [laughing], cause it's hidden, the chocolate, hidden in the freezer, I mean they have got their cupboard of sweets and stuff [laughing], so it's not like they go without but it, it's my time, it's my chocolate [laughs], and I like to be selfish so that's what , that's how I see it, I don't want to eat it and think I'm a kid and go like, oh, I feel sooo guilty eating this, no not at all". (P.14).

As this discourse clearly shows, secret eating and hidden foods are concealed for rewarding or treating 'self' in order to take control and position 'self' as having the power. The company of others seems to act as a break on eating behaviours, and this discourse shows how some participants actually chose to put themselves in circumstance where they could eat, albeit secretly. Therefore, the secret eating challenges the lack of control discourse, as it is intentional. The participants in this discourse are eating in order to give themselves something, therefore in opposition to other discourses they are in control. Throughout this and the previous discourses, there is an elusive feeling reflected by participants, as described by the drive discourse, one that overpowers them and leads to either a lack of control or a treating of the 'self'. Whatever this phenomena is, participants reported having an internal battle with them 'selves' in order to try and resist the overwhelming urge to respond emotionally to an event with food.

7.2.5 Battle of 'will' discourse

The discourse around a battle against diminishing self-will was evident in many interviews. The discourse of 'battle' reflects being engaged in something, a fight or a struggle to either achieve or resist something. In this discourse the sustained fight between forces trying to overcome each other was one of, diminishing 'self-will' vs. control. The battle is reflected in the discourse as participants punishing themselves with food, there are however within this battle, two differing positions, one defending

and one attacking 'self'. Throughout this discourse the language used was one that reflected 'battle' terminology. Following on from the discourse of using food as a 'treat' to try and take control, the battle discourse reflected that participants often felt a disappointment with the lack of will power;

I. "ok, and how does that make you feel when you feel "I shouldn't have done that"? [over-ate]

P. errm, how do I feel errm, a bit, not self-loathing, but a bit, yes, I should have been better, I should have had a bit more will power not to do that cause I know, cause I know that's how I feel but you still do it sometimes so yea

I. ok, so not self-loathing but.....

P. a disappointment, yea, I would say that, I am not actually angry with myself but disappointed with myself". (P.11).

The language used here by P.11, is one often reflected in this discourse, one of a controlling nature, "I should have", which is indicative of a battle between the loss of 'will' power and what is felt 'should' have been done, almost a 'moral' obligation or duty to be a better person and resist food. Participant's narrative was often chastising in nature, reflecting a battle not only against being unable to resist the food, but also against their 'self'. In this discourse of battle, food was often constructed as the enemy, something to be defended against;

P. "I don't always like food either though, I sometimes get cross with the blasted stuff, it's a nuisance as well, isn't it

I. as in,

P. planning, mmmm, mmm.... [some missing text]....

I. so what type of foods do you go for?

P. biscuits are the worst things, bread, definitely carbohydrates I think

I. and butter?

P. yea, I don't have real butter in the house anymore because it is dangerous [said in a soft drawn out voice to accentuate it]

I. butter is dangerous

P. yea, yea it's dangerous stuff'. (P.3).

Immediately we see the word, "blasted" (P.3) to describe food in a damned and hateful way, something which gets in the way, to distract P.3 "it is a nuisance". The enemy of 'food' is perceived as being "dangerous" (P.3) one to be avoided, similar to the 'addiction' discourse within the 'lack of control' discourse. By attempting to assert control over foods and avoiding temptation, participants were found to defend their position in the battle discourse; otherwise foods may overpower them;

P. "I think the trouble is it's best not to have things in the house, cause you, if you know they are there, errmm, I mean recently my husband bought a great big bar of chocolate,...[some text missing]..... and it sat up in the cupboard there and I knew it was there, and I kept saying for goodness sake, I said give it to somebody cause you know, all the time, you know it's there, you are so tempted, but kept looking at it and walking away, so I was very good .....[some text missing]..... it would be hard, I would try to avoid it for a while, but nine times out of ten, after an hour or couple of hours, I might go and try it, you know". (P.6).

Here we see a clear example of the battle against diminishing 'will'. Similarly to P.6 above, participants often constructed this discourse around being fearful of having food in the house, in the event that their 'will' may diminish. This discourse contained feelings around food having the power to *overpower* participants. However, another participant defended her position of not being controlled by food;

P. "Umm, well I'm not that interested in food, and I hate the thought of having to plan what we are going to have for dinner, and if it could come out as a pill, that you could just take and it gave you everything you needed, I'd be really happy

I. ok, so food doesn't

P. doesn't control me, at all". (P.16).

P.16's narrative is emphatic, and constructs a strong position of food being positioned and dismissed as irrelevant. Often, in this discourse, the act of 'planning' was discussed as a chore. Interestingly though, in P.16's narrative, she states an almost 'non-battle' firm position, but needs a "pill" (P.16) effectively wanting medicine to make her position more tolerable. However, after constructing this position, P.16 then contradicts her position of 'non-battle', reporting that she does indeed have to defend her position and control food. A position that is synonymous with other narratives reflected throughout the discourse of battle;

I. we started off the interview by you saying that you don't think of food at all, then you, in another part, say since you were 16 you've been controlling your food, so I am just wondering

P. yea, yea, I think it's probably, maybe, I don't think, maybe I think, food is an inconvenience because I have to control it, I don't know". (P.16).

After the discourse of P.16 initially reflecting no interest in food, the above narrative reflects a need to control food, and therefore, even though she initially took the position of 'non-battle', this discourse actually places her in a continual position of defence.

A further almost sub text which ran through the battle discourse was one where participants reported giving something to another emotionally, or being 'brave', which then resulted in them having to try and defend their position of control after the event;

P. "I try and be brave for her and say, oh you know, it's ok, this that and the other, then when I come off the phone I think, ooh, I'll have a cup of coffee and the biscuits come out, so as I say it all triggers, and I'm not saying it's her fault, I don't mean that, but I need that comfort for myself and I don't know for a little while it does make you feel nice when you've got something nice like a cream cake or a bar of chocolate or, but as I say it's just afterwards you think, oh I really wish I hadn't had that". (P.20).

This discourse, often reflected an external event that left participants with diminished resources resulting in them becoming more vulnerable to attack, unable to hold the power and defend against their lack of 'will power' over food. As with P.20, participants constructed this discourse around, subsequent to 'feeding' another they needed to feed their pain, which resulted in an attack on themselves. The battle discourse further demonstrates an attack on 'self' with participants reporting being angry with themselves after their out of control eating behaviours;

I. "how does that make you feel

P. I just get annoyed with myself that I have given in and had it really". (P.20).

And

I. "and how do you feel afterwards

P. terrible, can't believe I've done it so, and then I get upset that when you go to weigh in and I wonder why I put 2lb on, then I get cross with myself inside, and beat myself up over it, I get angry, only with me though, but inside I think why, why have you done that and give yourself a telling off really". (P.21).

The discourse of battle often reflected the use of the battle type language, participants regularly used terminology as demonstrated by P.21, "beat" and "tactics". Within this discourse the use of battle language was often directed at others as a means of attack;

> P. "what I do, I normally focus on something or someone out of the group, [SW], and see what they lose and see if I can beat them the following week, yea and I have been doing, this week obviously cause of Easter I've failed miserably, but generally that's what I normally do, try and do that.....[text missing]..... listening to other people's ideas and solutions and trying different tactics to beat them and yes just generally going and trying to get different new ideas to lose that extra, where Martin, he's tiny, he doesn't have, he can eat that rubbish where I've only got to sniff it and it's on". (P.21).

A battle such as P.21 describes existed throughout this discourse, a battle attacking self or others, reflecting participants trying to gain a position of superiority and win this war against weight. P.21 tries to "beat", other group members at the weight loss group. However, as is often reflected in this discourse, when the attack is not successful participants reported feeling defeated, "I've failed miserably" (P.21). Participants then needed someone to bear the pain or shore them up, to give them new "tactics" (P.21).

This discourse was often constructed around envy at others who can "eat that rubbish" (P.21) this phrase was usually stated with an element of envy and a covert angry edge, as with the example of P.21. Here we see another example of covert anger at another who is reported to have "always been very thin" (P.5). The discourse reflects a position of both attack on mother, and defence of self and self-will;

P. "um, well she, [mother], um, she's always been very thin, and you know sort of neurotic about it, and you know, I think as a child and a teenager, up to my early twenties I was very tall and thin and never had to worry about weight, and I think she feels I should be back like that really

I. does that feel like a pressure

P. urr, well, if, probably I say no, but, I haven't told her I go to SW, so it must be [laughs]

I. ok, so there some secret that you have to go to SW and lose weight?

P. yes, I don't have to, I can tell her, I don't mind if she knows, but I have just chosen not to volunteer the information, because, I don't want, you know, oh 'how did you get on', oh, 'I didn't lose any weight', oh, 'well you know try harder this week', perhaps it's a bit of, you know, I don't want to prove her right

I. mm, that you went to SW to lose weight

P. yea, that she thinks I should lose, yea". (P.5).

Just as the 'secret' discourses reported in the treating and rewarding discourse, here we see secrecy in the battle discourse. P.5 reports what was commonly reflected in this discourse, the need to take and hold control against another force. There is juxtaposition though in P.5's narrative, one of, "I don't mind if she knows" vs. "chosen not to" tell her. Other participants however, reflected needing the support and shoring up of another, in opposition to battling against it, they felt defeated and welcomed some support in the battle against their diminishing will;

P. "well, it would be nice to think that maybe you could say to somebody I'm, I'm struggling here and, and you know, help, but really, no I don't think, the only person that can do it is me…

I. but there is part of you that wants somebody else to help you

P. I would love to be able to say to my husband, don't, you know, don't let me eat that, or only make me, let me have one portion, but he wouldn't and I couldn't ask him really". (P.15).

The battle discourse clearly reflected how participants moved through the battle scene of defending their position against a lack of 'will', to attacking themselves when their 'will' diminished, to a defeated positioning of needing the support and back up of re-enforcements from external forces. Participants were often found in this discourse to report feeling as if they were lacking in the power to fight for sustained periods of time as with P.15 above. Participants reported needing someone to "make me, let me" (P.15) succeed. Maybe this was one of the functions of being part of a slimming group? Participants reported SW as having two functions, one of support and one of competition, both of which added to participant's resources to go into their own personal battle against food. There was however, a knowledge and understanding that the only person who is really able to do this was the participants themselves "the only person that can do it is me" (P.15). The battle of 'will' discourse reflected a continual cycle of loss of power and control, leading to eating, then to a need to once again take control. This cycle is reminiscent of the "weight cycling" reported by Kelly Brownell (Brownell et al., 1986).

7.2.6 Lack of self-efficacy discourse

Following on from the 'battle of will' discourse, the need for participants to have external re-enforcements reflected a potential lack of individual agency. A person's belief about their capacity to accomplish a task or to succeed is dependent upon their "self-efficacy" (Bandura, 1977). Self-efficacy accounts for, amongst other phenomena, a "resignation and despondency to failure" (Bandura, 1982, p.122). Having reported battle discourses and the defeat of the battle, many participants discourses were constructed around a powerlessness and lack of belief in their ability to succeed in the task of dieting. Discourses around being 'last on the list' and not having the internal wherewithal to continue the 'fight', all reflected a lack of sense

of self efficacy. The sub text also running through the participants' constructions was that of body image, how participants see themselves, this also reflected a lack of self-esteem and efficacy to change. There was a polarity within this discourse; the knowledge reported that feelings around sustainability of dieting can only come from oneself, and participants actually being able to achieve this task. The latter at times was reported as being beyond the participant's capabilities. Powerless was reflected as a lack of will power;

P. "I usually give in, that's why I can't diet, I can sort of be good for a few days and then I think, right today I've got to do it,

I. so what is it that stops you dieting do you think?

P. errm, I think lack of will power and, I don't, I don't know really to be honest with you, I'm not, I don't, I'm not a very determined person, sometimes I'm not very competitive so, so, so, so, if I go with someone to the you know to the slimming club, I think if she's lost more than me, I think oh well, fine, that doesn't bother me, so I don't wanna lose weight to beat someone, if you see what I mean". (P.11).

The example of P.11 reflects the narrative in this discourse whereby participants often reported feeling lame and unable to find the self-efficacy or belief to succeed.

Participants reported that the amount of energy needed to sustain a solid sense of individual agency and complete the task of weight loss, was at times beyond them, "I usually give in, that's why I can't diet" (P.11). This discourse reported participants feeling 'last on the list', when it came to their needs being put before others;

I. "it sounds as if you have to be very focused

P. I have to be able to do my own thing, to get the right food in the house and to eat it regularly and to know what I am doing a day in advance

I. Ok, you have clearly said that you do not have time to look after your own emotional well being

P. no that's right, I am the last on the list

I. you are the last

P. that's right, yes I am". (P.4).

Here we see P.4 clearly starting the narrative as knowing she has to be in control to, "know what I am doing", and constructing a position as having some agency, however, she very quickly changes positions to being 'last on the list'. In this exemplar we can see the powerlessness and insignificance in respect of the needs of others. P.7 is an example of this by clearly positioning herself as feeding all the children breakfast first, before needing to be cajoled by her husband to eat herself;

P. "on a normal day food's not really like top of my list at all, obviously I'm really busy, I've got four kids and you're up in the morning and you, umm, about 11 o'clock, I might feel, oh I feel hungry, and then I'd have whatever, I don't have to be hungry to eat, in general like, but by the time all the kids and that are done, he [husband] insists then that I have something and I would eat. Errm, I think as a parent, women, you are so far down the list of them". (P.7).

This discourse often positions participants as not being as important as specified others, participants reported having an inability to feed themselves properly when busy doing for others, and a psychoanalytic need for 'mothering' themselves. The narrative of P.7 reflects clearly the need for another to take control and feed her; reminiscent of the energy depleted narrative of the battle of will discourse. Reflected throughout this lack of efficacy discourse, participants reported an inability to put themselves first. This discourse clearly reflected some parts of the earlier battle constructions, whereby 'will' was conceptualised as a resource, as an energy which is finite and drawn off by other events, people or emotions. This is turn presented in both discourses as a lack of will power and capitulation to eating. The depleted lack

of self-belief is clear in the following piece of narrative which is a typical representative of this discourse;

P. "Quite often like I want some more like, ok I might as well carry on now until, until I put all my three stones back on, that, that horrible feeling of punishment

I. like a bit of a yo yo, where the reward comes but you feel you want to punish yourself afterwards

P. that's it, that's it, that's what I mean about comfort foods because you're not comfortable for long, you're just not, no no

I. so afterwards you don't feel comforted at all

P. no, no, afterwards I think, well done Michelle, you've blown it again!." (P.3).

Above is a clear example of the inability to achieve and keep control, there is also some element of self-blame reflected in the narrative that P.3 has not been able to manage her resources properly and has a punitive attack on 'self'; "you've blown it" (P.3). This discourse of lack of self-efficacy was marked in one participant's narrative, which demonstrated clearly an example of the disturbing and painful feelings often reported in this discourse with regards to being overweight and the lack of agency or efficacy to change. After constructing a narrative around her comfort eating, which she reported as doing "a lot", and eating anything "that puts the weight on really" (P.13) the discourse continued;

I. "do you think people see you as yourself, as someone who comfort eats a lot,

P. errm, I don't know really, I mean that the comments I hear sometimes, that you know, that I'm fat and that, makes me sad..... [at this point participant started to cry profusely]

I. would you like me to stop the tape, [participant nods], I'll stop the tape

Researcher stopped the tape

Tape was re-started

P. I quite often have little [laughs], little burst outs [laughs]

I. for the benefit of the tape, I have just restarted the tape, as the interviewee became quite upset,

P. yea, it is when people talk about me being overweight, it upsets me and I see skinny people around and I wish I could be like them". (P.13).

Here we have clear reporting of just how painful and upsetting being overweight was to some participants throughout this discourse. P.13's account shows how emotion breaks free; her equilibrium is lost in her "burst outs" which resulted in an explosion of emotion in the interview. The perception of the participants by another was a sub layer of this discourse, lacking a strong sense of self or efficacy resulted in participants becoming upset and unable to fight against other's view of them, as in P.13's account. There was a clear envy of slim people reported who do not have the same difficulties as this sample group. The longing to be different but without the perceived ability to change;

P. "I just didn't like the way it was, I didn't like the tummy that was coming and just like, 'no hide it', 'it doesn't exist, don't look, doesn't exist, don't like the neck, doesn't exist, keep the chin up and it makes it look a little bit smoother' [laughs]

I so you really denied that it [fat] was there

P. really, really denied it." (P.8).

We can see from this discourse how a distorted view of body image was underlying the discourse of lack of efficacy, the inability to have the individual agency to change

what the participant disliked about themselves. When asked how participants thought others saw them the following extract describes a common theme;

P. "losing weight, it sort of, it really muddles you up doesn't it

I. in what way

P. well I still feel overweight and I still look at the wrong size clothes, but I must be thinner than I think I am, I've only got to eat one day to feel fat again, immediately, as if the whole three stone has come back

I. mmm

P. yea, yea it is, whoof, Michelin Man, there she is!." (P.3).

Clearly, P.3 reports how the internal perception of 'self' is still at odds with the actual reality after weight loss. The two parts externally and internally, appeared in this discourse not to be united, leading to body confusion and a distorted view of self;

P. "I don't think people see me as being really overweight, but I think I see myself as being overweight". (P.11).

Participants often reported in this discourse that a specified individual's opinion of their size and weight really did matter. A reliance on another's perception of them reflected in this discourse feelings of hurt and pain;

P. "they don't look on me as really fat now, but Tim always used to say to me, oh you shouldn't have that, you know, it's for your own good, and to top it all once we went out to a party, and err, Christmas party it was, and we come home, and he said, do you know, he said, you were the fattest one there, that's nice isn't it! [laughs]..... I try to cover it up and they used to say, oh you

haven't got to worry, you know you're not *that* overweight, and I thought no, they don't see me, [laughs], when I undress you know, you know yourself don't you, and you know how you feel in bed and that". (P.9).

Although the perceptions of another, were clearly presented as being a source of pain, as with P.9, at times participants were unable to access any emotion connected with their inability to take control and succeed, resulting in participants being clearly affected by another's perception. P.9 laughs at what is clearly painful narrative, there is fragility about this discourse, but participants often disconnected from the issue with the use of laughter. Interestingly the majority of the participants' discourses reflected feelings of anger towards 'self' but not towards another. This will be returned to in the discussion section. The final example in this discourse shows clearly the disconnection from emotion after constructing narrative around an episode of comfort eating;

I. "so there's no remorse afterwards you say, at all

P. no, not that I can access, which is as if I shut it off and just move on, but I kind of wish I did feel the remorse because then I would be able to realise that it is wrong and stop doing it [comfort eating]". (P.24).

Above, as often reflected in this discourse, P.24 clearly positions herself as having no control or self-efficacy over the task in hand. This discourse raises the question of whether participants actually have the ability to gain some efficacy to stop the destructive eating behaviours and access some control.

7.2.7 Public vs. Private image discourse

The final discourse to emerge from the interviews was one around a public and private image. Within this discourse participants reported two distinct sides to their

eating habits, one that is open and shared and another that is hidden. This discourse had similarities to the discourse around secret eating, but the onus in this discourse was on how the participants managed the difference between the public and private image. The stronger the public image of being in control is portrayed to society, the higher the sense of failure and sense of entrapment could be for participants. Participants reported acting in front of others as if they were in control of their eating and sticking to a healthy eating plan, an example of this is P.1, who reported buying a cake and eating it secretly in the car even though she had lunch prepared at home with her parents;

> P. "I bought myself some chicken, cooked it and that was ok, and I had that for my lunch when I got home, so I could have just eaten the chicken,..... [some text missing]..... but I needed the cake, I needed the chocolate, it was a chocolate brownie cake". (P.1).

This discourse constructed a split between what participants did and did not show to society. There is a clear dichotomy of what is shown in front of others, as in the example of P.1 looking in control with the healthy chicken, and what is consumed in private; the cake. In the second example, this discourse reflects an almost virtuous face to others at the detriment of 'self' needs, leading to a deprivation;

> P. "last night we had a big barbeque and everything, I didn't have a piece of cake, didn't have the champagne, didn't drink, because I was making sure everyone else was alright, then this morning I've got up and feels like my stomach's been slit where I am starving". (P.21).

This discourse often reflected how the deprivation and image put on for society or others could not be maintained. The juxtaposition of images that participants had of themselves, good vs. bad, was reminiscent of the Madonna and Whore discourse

around women which Ussher (1997) describes as splitting them "from their true sense of self" (p.86).

P.21 shows how she is biologically hungry from the deprivation, which leaves an emptiness "feels like my stomach's been split", and a void. The difficulty in participants maintaining the two approaches to eating is highlighted further with P.18, whose narrative is an example of the discourse often seen in this public vs. private image discourse, that is the weight of emotion participants experienced resulting from a private eating episode;

I. "so what did it make you feel about yourself afterwards?

P. afterwards I felt awful [laughs], guilty [laughs], when I looked at what I'd eaten cause I wasn't hungry when I started to eat it, and I certainly wasn't full when I'd finished cause I could have gone on I think, but it just, I did feel awful afterwards, why did I eat it, but it didn't stop me eating it, I felt guilty till the next time

I. were you angry with yourself?

P. oh yea, for eating it definitely, guilty and angry, angry with myself for even starting it, if I didn't start, once I'd started I couldn't stop, that was the problem..... but nobody ever knew, I would go to bed at night crying cause I didn't want to wake up the next morning, because I didn't want to go through it all again, but nobody ever saw that, until one day I just, it just came out, and even my husband said, why didn't you tell me cause I didn't know, cause I was all bubbly and all happy

I. almost like there was this person at the front and the person inside being satisfied with food

P. yes, yes yes, definitely". (P.18).

The discourse around "nobody ever knew" (P.18) is an example of how participants were often unable to share their emotional needs with others, as if there was some form of shame being felt. This resulted in a painful and distressing experience, one which was ultimately unable to be hidden. The sub text around shame emerged in other discourses too, feelings described by participants of their failure to reach aspirations set by themselves or others. This will be explored more fully in the discussion section. Narratives reflecting participants being "all bubbly and all happy" (P.18) on the surface until such times when participants were overpowered by emotion, were often found in the public vs. private image discourse. Interestingly, P.23's narrative offers a succinct explanation for the need to have a public and private image;

> P. "I think it's a bit of rebellion, cause everything, if I'm told I shouldn't do it, then I'll do it, and I think that goes back to when I used to smoke and my parents wouldn't let me, and so directly I was out of their sight I used to smoke my head off [laughs], errm but when I was with them all day and all evening I never smoked". (P.23).

Here we clearly see in P.23's narrative, what was commonly reflected in this discourse; a need to rebel or revolt and be disobedient towards external control. (Again as in the previous discourse of lack of self-efficacy, the point is raised with regards to anger which will be discussed at a later stage). Participants often reported their needs having to be subordinate to another's. The inability to show their eating difficulties to society was reflected in this discourse by participants having to keep the real person hidden with a private image. Throughout this discourse of public and private image, the sub text which further layered this discourse was participants reporting almost taking solace in being part of a like-minded weight loss management group;

P. "it's a support and it's like a weekly reminder cause I find my resolve is far stronger on the Thursday and Friday directly after the meeting than it is on the Monday or Tuesday just before". (P12).

Participants reported needing 'something' external to back up the private image of eating and support their "resolve" (P.12);

P. "I think when you come and hear everyone else it's like, well you're not the only one, cause I think you think, God I'm the only one who can't lose weight and also umm, when you hear other people it's not as easy as you think, I mean people say, it's easy to lose weight, well it's not, I mean, I can lose it but I can't keep it off, I've done, I've been dieting for probably the last 15 years of my life and I do lose it but it all goes back on". (P.20).

The narrative of P.20 clearly reflects what was commonly reported regarding the private image, one where participants felt as if they were the only ones who are going through this process. Similar to the battle discourses, this discourse highlighted how the camaraderie of being with people within the same group, 'The Army', made participants state a sense of belonging as they were "all in the same boat" (P.13). We can also see in this discourse, as in the previous discourses, instances of weight cycling (Brownell et al., 1986) the repeated dieting, "15 years" (P.20). Within this sub text, there was found an overriding narrative of someone else being needed by participants to know how they felt, to have the "back up" (P.19) "knowing others are going through what I feel at the moment" (P1) "being with people who know how you feel about your weight" (P.8). The need for external help from another is clearly highlighted in the following example;

P. "if I do it at home, I might do it alright for four days, and then I think, well who's going to know, and nobody else knows whether I've lost weight or not

I. So the motivation between being at the group and being at home, what's the difference?

P. At the group I have to report to somebody, if I do it at home I don't need to report to somebody, yea yea if I wasn't in the group I would feel I could eat, but by going to the group I can't". (P.23).

This discourse highlighted the need for external validation and support in order for participants to understand and control their overeating. This discourse also reflected how difficult it was for participants to find this validation either internally or externally in society, hence the need for the private image. The public vs. private image discourse illuminates what participants reported to be the advantages of being part of a private group which seems to offer the control that participants lacked when alone. Within an externally controlled environment, the public and private images of each participant can find a space for themselves to be one. However, it is a 'private' group of other private images. Participants interestingly also reported in this discourse the non-tangible phenomena that has been reported in almost all previous discourses. This inexplicable phenomena was reported by participants as being something they were unable to make sense of or understand, leaving the question what is it that results in participants being unable to control their eating on their own;

P. "this is ridiculous, I know what I should and shouldn't be doing, why do I need to pay nearly £5 for someone to tell me!" (P.5).

7.2.8 Interrelationship of discourses

All discourses were layered with subordinate discourses which over lapped and intermingled throughout. Most participants described 'food' as an obvious necessity, as in, you need to eat to live, however almost all participants described food as having another function for them. The **genetic discourse** was described by only three participants; two positioned the genetic reasons for their overeating as a

vulnerability which allows for some agency, and one positioned the genetic reason as a fête accompli, beyond their control, no agency. Almost all participants' narratives referred at some point, to an inexplicable **drive**, this was reported as a *feeling* that was almost indescribable and non-tangible. To eat seemed to be an automatic emotional reaction rather than a biological response to hunger. There was a difference found between the genetic discourse and the other six discourses, the latter were commonly constructed as life events being the causation of some form of emotional response, which resulted in emotional eating with no organic cause. External events often imposed conditions outside of a participant's control which lead to a sense of impotence, and powerlessness, resulting in a discourse of **lack of control**. Other participants who did not feel trapped by these circumstances tried to gain some control by turning to food, using it like a "weapon" (Orbach, 1978) to fight against the life event, to alleviate stress or emotional distress and soothe themselves. The discourse of **treating 'self'** emerged as a way to remain in control. However, the treating of 'self' led ultimately to an internal **battle of self will** to try and stay in control, with participants needing to both attack and defend their position. The battle consisted of participants either attacking or defending themselves. The energy that was needed to continually fight a battle left participants depleted, and through the discourses ran an underlying **lack of self-efficacy** discourse with participants positioning themselves as 'last on the list' and having no ability or capacity to accomplish the task of weight loss. Interestingly there was also a **public and private image** that participants showed to the world with regards to their eating, which was instrumental in the joining of a weight loss management programme in order to gain camaraderie with like-minded people.

Let us now discuss these findings in relation to existing literature, and reflect upon the limitations and implications of this study in terms of clinical practice and future research.

8. Discussion

8.1 Theoretical and Conceptual Implications

As set out previously, the aim of this study was to investigate Emotional Eating and in particular the process which underlies eating for comfort. The aim of the research questions was to identify what discourses women used when describing their relationship to food, to ascertain if, and if so how, emotional regulation was acknowledged in these discourses and to explore whether women recognised, in these discourses, emotional eating. If emotional eating was recognised, how did women use food for comfort? Therefore, with this in mind, let us discuss the overall findings.

Language is used as a construction of a participant's viewpoint; it also enables the invisible to become conscious and expressed (Seu, 1996). Therefore, this research study has, from the discourses, enabled participants' viewpoints which they may otherwise have been unable to find words to express, to be expressed. In this research I have tried to make sense of and highlight the invisible processes which underlie the complex behaviour of comfort eating. In 2013 women are seen as 'having it all', meaning the best of both worlds, however, Petrassi (2012) citing Greer (1999) states that women 'having it all' means, women have all the work. Petrassi's study supported this claim and found women to represent "cultural ideologies in society that position gender inequality as normal" (Petrassi, 2012). Therefore, trying to maintain the work life, home life balance seems to come at a price; that of depleted energy. It would appear from this study that, lack of energy to sustain the positive effects of being in control of eating was central to the participants' discourses. This new age woman, doing everything, appears to be energy depleted and exhausted.

Similarly to previous research on obesity (Kaplan & Kapland, 1957, Bruch, 1973, Herman & Polivy, 1975, Slochower, 1987, Ganley, 1989, Van Strien, 1994, Van

Strien & Ouwens, 2003, Geliebter & Aversa, 2003 and Evers et al., 2010) this research study found that women discoursed emotional distress as a mediator when describing their relationship to food. As seen in the literature, this study also found participants' discourses around emotional overspending and undernourishment (Heenan, 2005) which left participants depleted.

There were seven main discourses found in this study within which, participants described their relationship to food, in general, as being disordered. There existed a tension throughout most discourses which underpinned the participants' eating; this tension indicated that the participants constructed their relationship to food as an out of control behaviour. The genetic discourse, although different in as much as it was not reported as an external event causing the eating, but one that participants discoursed as they were either born with or had a genetic trait for, still indicated a tension around lack of choice or control similar to all other discourses. The study found that participants discussed food in accordance to Orbach's findings (1994b) as being dangerous, and they used their bodies to express their emotions. Participants battled through the lack of control, and the discourses around depleted 'will' were evident.

There was a definite recognition by all participants in the lack of control discourse that their out of control eating behaviours were in some form an emotional regulator. Although at times participants acknowledged they were comfort eating to regulate something, they did not know what that something was. Food was used as a mediator constantly between feelings of lack of self-efficacy (Bandura, 1977) and being able to reach a target. From a psychoanalytic point of view, this is an interface between conscious and unconscious processes in agreement with the findings of Heenan (2005).

Throughout all the participants' interviews, with the exception of one, comfort eating was clearly recognised. The missing factor within the discourses was the process as to why participants were comfort eating, rather than the act of comfort eating itself.

This study produced clear evidence of repeated weight cycling (Brownell, 1988) especially within the lack of control and self-efficacy discourses. All comfort foods described were nutritionally poor, high in sugar and high in fat and this concurs with the research of Dallman et al. (2005). In line with Dubé et al. (2005), Locher et al. (2005) and Le Bell et al. (2008) nearly all participants positioned food as alleviating distress and negative emotions. There was limited evidence found in this study of the classifications of comfort foods as described by Locher et al. (2005). Only one participant spoke of childhood memories, the 'nostalgic' concept identified by Locher et al., as being associated with comfort foods, although, participants discourses did reflect a 'mothering' of the 'self' when using food as a symbol to replace missing attachment figures from a Bowlbian perspective (1969).

Where this study differs from previous studies is that, although participants reported an ineffability to describe the process that lies behind emotional eating and the use of food for comfort, within this discussion I would like to offer an explanation into the identification of these processes, as called for by Wooley (1995) from a psychoanalytic framework perspective. All participants' discourses reflected their position of being trapped in a disordered way of eating which they described as being 'difficult'. Their capacity to be able to do anything to control their behaviour appeared to have diminished, or was limited in the first place due to an over expenditure of energy, therefore, there ensued a battle of 'will' discourse and an attack on them 'selves'. This behaviour could be seen as self-harm. Interestingly though, throughout all discourses, there were no direct references found relating to angry attacks towards others, despite there being a clear discourse of 'battle'. The only discourse that came near to displaying anger was discourse around the envy of others who were slim, although this again, was covert and not overt anger. Even though numerous discourses reflected pain and hurt when participants spoke of their position with regards to a significant person in their lives, the participants never discoursed any manifest or overt anger towards another. Words were used such as annoyance or disappointment, but never anger towards another. So the questions reflected upon are, where is the anger? And is comfort eating a sublimation of repressed anger? Anger is seen as instinctual, and although this is not a psychoanalytic analysis, and therefore it is beyond the realms of this study to go into

the depths of psychoanalytic concepts, participants did seem to reflect a conformation to higher social values (Freud, A. 1979). True sublimation is socially accepted (Rycroft 1995) it is a defence, one that Anna Freud lists as pertaining to the study of the normal rather than neurosis. So this normal act of sublimation would appear to be what the participants have become accustomed to. This study suggests that participants swallow down their anger with food rather than confront some form of conflict. If we stay within an analytic framework, another defence mechanism that the participants in this study deployed was the process of splitting (Freud, A. 1979). There was evidence throughout the discourses of participants appearing to use the defence of splitting to avoid an alternative position, possibly one of being angry or confrontation. Participants discourse reflected splitting their behaviour into good and bad, that is; good/bad diets, good/bad days, and good/bad foods. The participants narrative throughout was one of accepting or rejecting, reminiscent of the good/bad object found in the object relations theory of Klein (1935).

The public and private image and treat discourses were clear reflections of a discourse which highlighted the act of splitting. Participants split their eating behaviours into one that was acceptable in front of another publically and socially, and one that was not. This discourse of image is similar to the eternal conflict between the two archetypal representations of 'woman' described by Ussher (1997) the Madonna and the Whore. Although changes in representations of 'woman' over the last four decades of feminist critique are evident, Ussher (ibid) puts forward this traditional objectification of women. The participants in the public and private image discourse reflected this split; the discourse was the dichotomy between acting as two differing people with the aim of satisfying or meeting the needs of another. This is also a reflection of Winnicott's 'true and false self' (1960). Furthermore, the discourse of public and private image reflected a clear element of the 'split off' part of participant's 'selves' as being or doing something that felt shameful; the defence mechanism of splitting is associated with shameful feelings being split off (Freud, A. 1979). Participants withdrew into the position of the private image discourse or secret eating in the treating discourse in order not to face a situation of conflict at failing to meet a standard which is socially acceptable. Seu (1996) sees shame as

having a crucial function, one of holding the boundary between what is seen as public and what is private.

Let us now discuss further how shame is one of the underlying processes which result in comfort eating. It sometimes appears that the terms 'shame' and 'guilt' are used interchangeably. Shame describes the inability to do things, feelings of incompetence, a self-image that is immature and a failure to reach the aspirations set by others or ourselves (Erikson, 1965). In his "8 Ages of Man", Erikson (ibid) described shame as a failure to negotiate the task involved in the anal phase of classical psychoanalytic theory (Stage 3; Autonomy vs. Shame and Doubt). If the developmental task of becoming autonomous is not achieved a child will be left with a lack of awareness of their own thoughts and actions, resulting in feelings of shame and doubt in their ability, similar to the lack of self-efficacy described by Bandura (1977).

Following the same stages, guilt however, is described by Erikson as a response to something one has done, rather than to what one has been unable to do (Stage 4; Initiative vs. Guilt). It is clear from the findings in both the lack of self-efficacy and public and private image discourses, that the participants' feelings of 'guilt' were recognised after an out of control overeating episode, one where participants felt they had not achieved their aim of healthy eating. However, this study therefore suggests, that participants used the word 'guilt' as an overarching feeling, rather than 'shame', which would be a more descriptive term as it comes directly from a failure to achieve control (Jacobs, 1994).

Shame is described as a sense of letting oneself down; a kind of 'disappointment', the latter was a word which participants used repeatedly to describe their position in the discourses. The discourses reflected a disappointment that participants had not lived up to their perceived ideal, actually feelings of shame are a direct result deriving from the failure to live up to one's ideals; "I cannot see myself as I want to see myself or as I want others to see me" (Sandler et al., 1963, p.157). Therefore,

the shame is first experienced as being outside of the 'self' and it is introjected, "swallowed so that it becomes a possession of one's own self" (Rayner, 1986 p.83). Interestingly, Rayner uses the term "swallowed" here, as this is part of the emerging processes underlying comfort eating, an inability to sustain control and power, resulting in participants overeating and "swallowing" feelings of shame, or anger. All participants reflected some type of feelings of failure when they were unable to achieve their goals. Where the participants perceived these standards and ideals had originated from was not evident in the majority of discourses. Only one participant made reference to where the standards by which she judged herself originated from. Her narrative sounded punitive and self-punishing, and when this was reflected back to her by the researcher, she answered, "that'll be my mother then" (P.24). Ferguson & Mendelsohn (2011) linked feelings of shame and disappointment with an early rage at the caregiver or a significant other, in a desire for human responsiveness. In line with further findings of Ferguson and Mendelsohn (ibid) this study found that participants discourses overwhelmingly reflected an inability to attune to their emotional regulation and self soothe in any other way than with food. Ferguson & Mendelsohn (ibid) purport this comes from an infant trying to make sense of early misattunement within the interaction with their human object; the mother. Similarly, this could be reflected through an Attachment, framework (Bowlby, 1969) as a result of an insecure attachment to the primary care giver. The discourse of lack of self-efficacy (Bandura, 1977) often reflected this desire for another to interact and support the depleted energy of the participants. Participants reported over various discourses, an inability to succeed alone, there was a clear desire to have someone shore participants up or take control.

The treat discourse clearly showed childlike narrative, both in terms of terminology used, and in practices deployed to 'hide' chocolate or comforting foods, in order to indulge at a later stage. The question is raised as to why would participants report behaving in a childlike way within these discourses? From the analysis, this study suggests that the childlike behaviour was to evoke feelings of parenting from other people, to invite unconsciously someone to come in and either take control or shore up the participants internal worlds. Was this again reflecting the need for an early positive emotional experience, one that is required for a secure attachment? By

inviting another to take control there would be a setting of boundaries, just as a child needs a boundary to feel safe. The discourses of lack of self-efficacy and lack of control often had a feeling of insecurity and uncertainty about them, these discourses reflected feelings of being overwhelmed by the out of control behavior discoursed within them. The study of this discourse suggests that by participants engaging in childlike behaviours, this would enable them to get some response from another; love or punishment either would suffice. This discourse seemed to be a fall back to a primitive state whereby the participants seem to be saying that they do not have the capacity to engage in adult responses to certain external events, therefore they will evoke the adult response from another. This discourse can clearly be seen through both a psychoanalytic lens, and that of attachment, but both lenses lead back to an insecure or disrupted early caring relationship. If we stay looking at this childlike discourse through an analytic lens, Freud's dynamic model of the mind gave us "id, ego and Super ego" (Freud, 1923). However, Bettleheim (1985) believes this terminology should have been translated in a more personal way, as in; 'it, I and over it'. If we think in terms of the discourse surrounding participants use of comfort eating in a childlike 'naughty' way, maybe this is an unconscious longing for responsiveness from another, the internalisation of the person 'over I'; the longed for love object (Greenberg and Mitchell, 1983). Participants positioned in the discourse, as being able to attain the ideal or standards perceived more easily once they ascertained the support of another, thereby relinquishing feelings of shame and failure.

Following on from the childlike discourse, if we now turn to the one phenomenon that was found to be woven through all the discourses; an inability to put into words the drive discourse. Participant's discourses reflected an "urge" to eat which permeated through the narrative constantly. Participant's narrative reflected and included many reports of how this urge overwhelmed them and took over them. The phenomenon was not tangible, but was almost palpable; participants could feel it but appeared to have no control over it. It was all consuming, but they did not know what 'it' was. Within this discourse participants referred to the urge as - 'it just took over me', or 'it was all consuming'. Therefore, taking Bettleheim's translation of 'Id' into 'it', maybe the childlike discourses around participants wanting an instant gratification of 'it', are

a reflection of the process of comfort eating being an unconscious response to an internal conflict with the 'over I', which is seen as an equal to the parental and societal controls of the super ego. This would be in line with the unconscious conflict described by Slochower (1987). It would appear that the process of comfort eating is in an attempt to resolve an internal conflict of the psyche, the giving to self – I want, in opposition to being over powered by the powerful super ego – you should not have. This conflict would suggest that there is insufficient ego strength, a type of fragility, which results in participants being unable to take and keep control, resulting again in feelings of powerlessness. This leads however, paradoxically to women taking control by eating.

All participants were asked to reflect upon what it was that being part of a weight loss management organisation gave them. Nearly all participants reported feelings of being part of something, someone else in control; they were encouraged by like-minded and caring people. There was also a fear factor. If they were not 'good' as far as the task of losing weight was concerned, participants reflected a fear of the scales that judged participants and become all-powerful; thereby providing another perceived 'ideal' standard to be measured by. The process underlying comfort or emotional eating on many levels seems to be cyclical. The positioning of women as increasingly carrying multiple roles requires resourcing, maybe the 'eating battle' also adds to this weight, resulting in inevitable feelings of failure and a vicious cycle. Maybe however, in analytic terms, Slimming World provides both the nurturing internalised object, which at the same time controls the 'it' by becoming the surrogate super ego.

I am aware that this discussion at times has taken on a psychoanalytic lens rather than exploring the discourse from purely the participants' narratives and using this as the only lens to explore from. I am also aware that three main factors became the focus of my reflexivity, and although all three contributed to the undertaking of the study, they also at times impinged upon it. These factors were; my interest in the research subject, my profession as a psychoanalytic psychotherapist and my experiences as a woman. Although language reflects an inner psychological state

(Midgley, 2006) I am aware that Edwards & Potter (1992) have historically "rejected psychoanalysis' claim to have access to a deeper level of psychic reality" (Midgely 2006, p.2). However, I have discussed the analysis and explored what could be felt, thought and experienced from within the participants' positions in accordance with Stage 5 of the framework set out by Willig (2001). I have tried to provide a "transparent account" (Midgley, 2006) of the participants psychological world from both their perspective, and mine as a psychoanalytic psychotherapist and researcher. I would argue that taking a psychoanalytic lens on a piece of discourse analysis could identify latent themes underlying the process of comfort eating. It could provide a potential framework to think about anxieties and defences that may underlie the narrative, and that this is a strong position from which to explore the emotional investment that participants have discoursed (Midgley, ibid). Let us now discuss these findings in terms of both the limitations and implications for practice and future research.

8.2 Limitations

8.2.1 Phase 1

The collection of data for phase 1 was internet based, the testimonials were self-reported which may have produced an over or under reporting of circumstances. The data collection was also restricted for ethical reasons, to open access 'chat room' sites, as opposed to those which needed a password or membership to access.

8.2.2 Phase 2

The limitations of phase 2 of the study can first be thought about in terms of sample bias. The sample was selected from one weight loss management organisation, rather than over a broad range, and from one group meeting. However, in line with a discourse analysis and in order to provide as broad a range as possible, all

participants over 18 years of age were included, with no restrictions on background. The sample was however, made up of only Caucasian participants, the study group did not include difference in terms of race or ethnicity. To include participants from different ethnic or race backgrounds could have produced differing constructions around food and comfort eating.

The ontological and epistemological framework underpinning this discourse analysis study will have affected what was seen and where the research focussed, it is only one possible analysis. Participants were aware of the research topic and my interest in it, they were also aware of my profession as a psychoanalytic psychotherapist, all of which could have in some way influenced the interviews. However, the latter issues were consistently worked through with the aid of supervisory input, challenge, reflexivity and reflectivity.

Another limitation to this study was the length of the interviews. Each interview was approximately twenty minutes in duration, and therefore not allowing for more than short answers to the interview questions from participants. The main issue that I found within the interviews was the tension that I held regarding the difference between a 'clinical' and a 'research' interview. As a psychoanalytic psychotherapist, I am drawn to offering interpretations, exploring contradictions and delving deeper into a patient's own self-understanding. These issues and those of transference and counter transference are phenomena that I work with daily. Therefore, making sure that I held the tension and appropriate boundaries for a research setting, one which is without a therapeutic contract, felt at times anxiety provoking. The tensions I held became obvious through my conscious awareness of not interpreting, and an obvious caution when using open questions to illicit more information. Therefore a limitation of this study was the overuse at times, of closed and or leading questions. I had a tendency to move on to the next question quickly rather than allowing the interviewee to maybe go somewhere that would illicit the analyst in me to respond, which in a research setting would have been inappropriate. However, I was able to hold this boundary and as the interviews went on I became more confident in my role as a researcher.

8.3 Practical Implications

From this study, food is clearly used as an emotional regulator, and the underlying process of comfort eating has been highlighted as a potential conflict of the psyche. Therefore, it is suggested that obesity management clinics and weight loss organisations, focus their weight loss programmes on the broader psychological features of obesity. The inclusion of psycho-education addressing the underlying thoughts and feelings around disordered eating is recommended. From this and previous research, there has been highlighted a clear gap in the knowledge surrounding the extent of psychological distress for emotional overeaters. Therefore, a more widely explored clinical understanding of the patient's experiences which underpin comfort eating is called for. However, psycho-education alone is not sufficient. This study recommends longer term Psychodynamic or Psychoanalytic Psychotherapy, with the overall aim of therapy being to address the internal conflicts that these patients may present with, and work towards establishing an internal 'sense of self' and 'self-efficacy', rather than just focussing upon the eating behaviours themselves. However, from the constructionist school of therapies, shorter term Solution Focussed Brief Therapy (De Shazer, 1988) could be employed initially to focus upon the immediate difficulties surrounding some patients' inability to change their eating behaviours.

The practical application of the findings from this research could help with the everyday problematic area of obesity. From a clinical perspective, by exploring a patient's understanding of where the standards and values they hold have originated from, an insight into whether these and other expectations of themselves are unrealistic could be ascertained. The insight gained from therapy could ultimately lead to change. With regards to both weight loss organisations and therapy, the ultimate goal of strengthening a group member or patient's ego and sense of self agency would be advantageous. As expressed in the discussion section, by weight management groups providing both a nurturing and boundaried, safe and facilitating environment, this may result in a positive corrective emotional experience, which ultimately could compensate for early childhood insecure attachments. By weight

loss management groups or therapeutic encounters providing a positive attachment figure, a new experience of secure attachment is likely to occur according to Hertz, Addad & Ronel (2012).

8.4 Research Implications

One objective of a discourse analysis is to link with the wider societal constructions in order to examine a concept as part of a larger context. This research only represents a small part of that overall picture; therefore further research could be aimed at interviewing a larger sample of groups, and using a more in depth, longer interview process. The research could include ethnic and cultural differences to further broaden the insights into the processes underlying comfort eating. Furthermore, the unique findings from this research study might be further validated by future research on Attachment and Emotional or Comfort Eating. There is a growing body of research on the link between attachment and the more severe end of clinical eating disorders, this research is now moving to include the area of Binge Eating Disorder (Hertz, Addad & Ronel, 2012). However, future research could be widened to include and examine the links between comfort eating and attachment styles. The focus might also include research incorporating and examining links between obese children, their environment and attachment styles.

Research to further deepen our understanding of the processes underling comfort eating, could also take a wider examination of the concepts of shame and guilt experienced by women in respect of their eating behaviours. Further research also needs to be undertaken with regards to men and comfort eating. The template for comfort eating seems to have been developed on women. Therefore, future research is recommended as to whether men sublimate their need to comfort eat into something else. Finally, research is recommended into whether weight loss organisations do indeed, as suggested by this study, provide a surrogate super ego which could result in creating a secure attachment.

9. Conclusion

Conclusively, as stated in the introduction, this study was born out of the ideas of Susie Orbach's first book, Fat is a Feminist Issue (1978). Orbach put forward a theory of women's dysfunctional relationship with their bodies and food. She explored the unconscious drives underlying being, and more importantly staying, overweight. Today, in her latest book 'Bodies' (2010) Orbach is still arguing that body contentment is hard to find, she has recently turned her attention to capitalism and purports that as consumers we are more influenced if we are needy and anxious, therefore body 'anxiety' is her focus (Orbach, 2010). Fundamentally, her basic tenets of overeating are still powerlessness and lack of control, which is in line with the findings of participants' discourses in this study. Over 30 years on, fat may not now be so much of a feminist issue but it is still an issue. As gender roles change in society, so we see changes in the epidemiology of eating disorders. However, the findings of Wells et al. (2012) suggest that the status of women globally is still a key area that needs addressing, with potential benefits for women, their offspring and the global obesity epidemic.

Overall, the multiple discourses in this study, constructed participant positions as being associated with repressed anger, feelings of shame and failure to achieve an ideal, and lack of self-efficacy. When analysed, the discourse brought forward an explanation for the non-tangible overwhelming 'urge' that seemed to take over participants which resulted in uncontrolled eating behaviours. The study also found that participants constructed positions of depleted energy, resulting in the need for another to assist them in achieving a goal, further highlighting the lack of self-efficacy. Given that, this study suggests from a psychoanalytic framework, that participants were potentially longing for a 'good object', to meet their needs reminiscent of the early mother infant relationship. Maybe, from a public health point of view the UK obesity crisis could be looked at from a relational perspective with regards to investing in the next generation of children, focussing upon their early childhood environment to foster secure attachment styles.

What may appear as a simple thing to much of society is indeed a very complex process. Overeating does not simply equate to too much food and too little exercise. Comfort eating is not a linear process, but one with a complicated structure disguised as simple. I see comfort eating as a spiral, it has depth and infinite movement, one that is indeed not a comforting recipe but can most definitely be a very destructive formula. At the heart of any emotional eating is a need, a need to satisfy an emotional hunger.

> "When I write of hunger, I am really writing about love and hunger for it, and warmth and the love of it and the hunger for it".
>
> (Fisher, 1976 in; Chernin, 1986, p.97).

10. Appendices

10.1 Appendix 1:

University of Kent Ethics Approval Form

FOR ALL APPLICANTS

I have read the Faculty policies regarding the use of human participants and agree to abide by them. I am also familiar with the ethical principles listed in the Research Ethics Handbook with regard to human participants. I further agree to submit any significant changes in procedures or measurement instruments for additional review.

Signed: Shirley Ashby.

Researcher(s) SHIRLEY ASHBY

Name: SHIRLEY ASHBY	Signature: Shirley Ash.	Date: 20/9/10
Name:	Signature:	Date:
Name:	Signature:	Date:

Supervisor: GEORGIA LEPPER

Name: GEORGIA LEPPER. Signature: Georgia Lepper Date: 20/9/10

Please remember to attach

- **your research proposal**
- **the participant information sheet**
- **the participant consent form**
- **any questionnaires, scales, measures, letters and phone/verbal scripts to be used**
- **debriefing materials**

Action Taken

- [x] Approved
- [ ] Approved with modifications or conditions noted below
- [ ] Action deferred. Please supply additional information or clarification noted below.

D J Oliver

Date 6/3/11

10.2 Appendix 2:

Participant Information Sheet

Participant Information Sheet.

March, 2011

Who Feeds Me: Women and Food - A comforting recipe?

You are being invited to participate in a research study to look at the difficulties women often have to control their eating and whether some people use food for comfort. This study is being conducted by Shirley Ashby at the University of Kent at Canterbury as part of a Doctor of Clinical Science thesis. You were selected as a possible participant in this study because of your connection with Slimming World, Lenham, Kent.

You can help in this study by consenting to take part in a short recorded interview using a standard audio tape recorder. The interviews will be held in the participant's home at a previously agreed time, therefore there will be no costs or expenses incurred by participating in the study. After the interview the tapes will be transcribed and transferred to a digital memory stick. The original recordings along with the memory stick will be kept in a locked safe. The tapes will be kept through the data collection and transcription parts of the study (maximum 1 year), and then they will be destroyed. Written transcripts will be made from the recording and will contain no names or details that might identify you. No one apart from the researcher and research supervisor will have access to the data. Ethical approval for this study has been obtained.

Participation in this study is voluntary. You may withdraw your consent at any time during or after the interview, at which time the recording will be destroyed. No names or other information that might identify you will be used in any publication or documentation arising from the research. It is hoped that results from this study will enhance our understanding of "comfort eating" and therefore make a contribution to the growing difficulties in weight management. A summary of the results from this study will be available from the researcher on request.

If you are willing to participate in this study could you please leave your name and contact details (telephone and/or email), on the sheet provided and the researcher will contact you. If you have any questions about this study please feel free to contact me, Shirley Ashby on 01795 886859 or S.Ashby@kent.ac.uk .

Thank you for taking time to read this information,

Kind Regards,

Shirley Ashby

Frequently Asked Questions

Where will the interview take place?

The interviews will take place in your home, at a previously agreed time.

What happens if I change my mind?

You can change your mind and withdraw from the study at any time during or after the interview.

What is meant by a short recorded interview?

An informal interview with the researcher will consist of a few questions being asked which will be recorded on a standard audio tape recorder.

What happens to the tapes?

All tapes will be transcribed and transferred to a digital memory stick. The original recordings will be kept in a locked safe and destroyed after a maximum of 1 year.

Do I get paid to take part?

No, as there will be no costs/expenses incurred there will be no fees available and participation is on a voluntary basis.

Can I see the results of the study?

Yes, the results of the study will be made available from the researcher on request.

How can I take part?

By either leaving your name and contact details on the sheet provided or contacting the researcher direct on the contact details in the Participant Information Sheet.

10.3 Appendix 3:

Participant Consent Form

Participant Consent Form:

I *(fill your name here)*.....,

consent to participate in the research study " Who Feeds Me: Women and Food - A comforting recipe?" conducted by Shirley Ashby. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature ..... **Date:**.....

Participant

Signature..... **Date:**.....

Researcher

10.4 Appendix 4:

Semi-Structured Interview Questions

Questions for Semi Structured Interview (Phase 2)

1. Could you tell me what food means to you?

2. Would you say you comfort yourself with food and how?

3. What types of food do you reach for in the main?

4. If answered yes to question 2 - How does eating for comfort make you feel about yourself?

6. How do you think other people see you?

7. Is there anything else you feel could satisfy these needs apart from food?

8. What is it that you think you get from being part of a slimming group?

9. What makes it difficult for you to lose weight alone?

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