Therapeutic Recommendations for Emotional Eating: A Delphi Study

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ABSTRACT

Emotional eating is a common behavioral phenomenon that involves eating in response to emotional impulses rather than physical hunger and is believed to be a form of affect regulation (Ball & Lee, 2002). While emotional eating occurs within the symptomology of eating disorders it also occurs independently (Benett, Greene, & Schwartz-Barcott, 2012). Further, a pattern of emotional eating can lead to weight gain and the development of eating disorders (Grant & Boersma, 2005). Currently, research is limited in terms of smart practice treatment recommendations for emotional eating. In order to address this gap in research, the Delphi method was utilized in order to gain consensus from a panel of nine experts regarding treatment recommendation specific to emotional eating. These panelists identified 47 treatment interventions that will be discussed.

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Chapter I: Introduction

The Problem and its Setting

For well over half a century, psychologists have studied and documented the relationship between emotions and the consumption of food. They have found that both food choice and quantity can be affected by emotions, this phenomenon has been dubbed "emotional eating" (Ganley, 1989). It is estimated that one-fourth to one-third of the population engages in emotional eating (Laitinen, Ek, & Sovio, 2002). Why individuals use food in order to cope is often complex, however, researchers have identified that this response frequently occurs in reaction to negative emotions. Indeed, numerous studies have confirmed that emotional eating is an attempt to regulate emotions or affect as food is utilized in order to numb and distract from these negative emotions (Ball & Lee, 2002; Denisoff & Endler, 2000; Freeman & Gil, 2004; Koff & Sangani, 1997; Oliver; Wardle, & Gibson, 2000; Van Strien & Ouwens, 2003;). While emotional eating is highly prevalent, there is limited information regarding therapeutic interventions specifically for emotional eating (Andrade, 2005; Bohon, Stice, & Spoor, 2009; Brown, brow, & Wrobleski, 2009; Ganley, 1988; Gross, Richards, & John, 2006; Heatherton & Baumeister, 1991; Macht, 2008; Martin, 2001; Spoor, Bekker, Van Strien, & van Heck, 2007; Van Strien, Frijters, Berger, & Defares, 1986). In addition, while emotional eating has been identified and treated as part of eating disorder symptomatology, it differs in nature and severity from eating disorders which are defined as chronic, causing substantial distress, physical and mental impairment, and psychiatric comorbidity (American Psychological Association, 2013; Hudson, Hiripi, Pope, & Kessler, 2007). Nevertheless, emotional eating can still cause frustration and distress and is linked with increased self-criticism, shame, unsuccessful dieting attempts, weight gain, as well as a greater risk of developing an eating disorder such as binge

eating disorder and bulimia nervosa (Grant & Boersma, 2005; Grilo, Shiffman, &Wing, 1989; Sarlio-Lahteenkorva, 1999 ; Stice et al., 2002; Van Strien, et al., 2005). Therefore, treatment practices for emotional eating need to be better understood and explored outside of the dimensions of eating disorders.

Emotional eating. It is common knowledge that emotions can induce changes in eating behavior in humans. How emotions impact eating can depend on a variety of both personal and environmental factors (Ganley, 1989; Greeno & Wing, 1994; Robbins & Fray, 1980). For example, the natural biological response to negative emotions and stress is typically the cessation of eating. However, for some, these emotions illicit the opposite reaction resulting in an increased food consumption (Macht, 1999). This phenomenon was first thoroughly investigated in 1957 by Kaplan and Kaplan who found a significant relationship between food over-consumption in obese individuals with anxiety. They discovered that eating was a way for individuals to soothe and thus cope with negative feelings and emotions related to their anxiety. They labeled this new phenomenon "emotional eating." Emotional eating has since been defined as the overconsumption of food in response to emotional, rather than physiological, cues marked by an tendency to consume sugary, high fat, and energy dense foods (Nygen-Unger, & Spruijt-Metz, 2007; Van Strien & Oosterveld, 2008). Indeed, the conclusion of over 50 studies on weight gain and obesity shows that emotional eating is consistently caused by experiences of emotional distress, including depression, anxiety, anger, and loneliness (Ganley, 1989). While emotional eating is associated within the symptomatology of eating disorders, most commonly binge eating disorder (BED) and bulimia nervosa (BN), it also occurs in individuals that do not meet the criteria for an eating disorder in accordance with the Diagnostic and Statistics Manual Fifth Edition (DSM-V) (American Psychiatric Association, 2013; Benett, Greene, & Schwartz-

Barcott ,2012; Canetti, Bachar, Berry, 2002; Ganley, 1989; Laitinen et al., 2002 Reel, 2013; Wilson, Nonas, & Rosenblum, 1993, Macht, 2008; Waller & Osman, 1998). Further, Latinen et al. reported in a 2002 study that in a group of individuals who were not diagnosed with an eating disorder showed a 30 to 48 percent increase in food consumption when experiencing emotional distress. Additionally, a 2012 study on college students that specifically focused on non-eating disordered emotional eating found eating occurring as a pattern of coping in response to stress (Benett, Greene, & Schwartz-Barcott). While emotional eating has also been found to occur predominantly in women that are overweight, it also occurs in women and men in the normative weight range (Agras & Telch, 1998; Polivy, Herman, & McFarlane, 1994; Tabor, 2006; Ganely, 1989; Macht, 1999; Macht & Simons, 2000; Ouwens et al., 2003). Studies have also found a higher prevalence of emotional eating in both men and women with depressive symptoms (Konttinen, Mannisto, Sarlio-Lahteenkorava, Silventoinen, & Haukkala 2010; Pidgeon, Lacota, & Champion, 2012). Emotional eating also occurs among all socioeconomic levels (Ganley,1989). This research has led to speculation that emotional eating is, in part, influenced by individual characteristics and the causality of this behavior and its relationship to social environment is complex in nature (Ganley, 1989; Greeno & Wing, 1994; Laitinen et al., 2002; Zysberg & Rubanov, 2010).

Emotional eating is considered a biologically abnormal response wherein the increased consumption of food is contrary to expected physiological responses during times of distress (Schachter, Goldman, & Gordon, 1968). Typically, distress triggers the sympathetic nervous system to send a message to redirect blood from the digestive system to the external extremities, in preparation for the fight or flight response thus decreasing appetite (Parker, Parker, & Brotchie, 2006). Emotional eating runs counter to this process and can distort the natural

physiological reaction over a period of time by altering the brain's reward system. For example, dopamine and other neurotransmitters associated with increased positive feelings are found to decrease in obese individual who eat in response to emotional stimuli (Davis, Strachan, & Berkson, 2004). In addition, when presented with a milkshake during a time of negative emotion, self-reported emotional eaters were found to have increased activity in the parahippocampal gyrus and anterior cingulated cortex areas of the brain which are linked with the brain's reward system. In contrast, non-emotional eaters showed a decrease in neural activity in their brain's reward system during both negative and neutral emotional periods (Bohon et al., 2009)

Emotional eating and emotions. It is widely believed that emotional eating is sustained and utilized as a way to cope with negative emotions by way of soothing, numbing, and distracting (Ball & Lee, 2002; Denisoff & Endler, 2000; Freeman & Gil, 2004; Koff & Sangani, 1997; Oliver, Wardle, & Gibson, 2000; Van Strien & Ouwens, 2003). These negative emotions typically include anger, boredom, anxiety, and loneliness (Arnow, Kenardy, & Agras, 1995; Ganley, 1989; Macht, 1999). Themes of guilt, shame, self-judgment, and perceptions of personal character flaws have also been reported in those who emotionally eat. Further, emotional eating is associated with negative self-judgment resulting in decreased self-esteem which then increases negative emotions. A strengthened pattern of coping by eating may then result (Hernandez-Hons &Woolley, 2012; Reel, 2013). Though negative emotions are often cited as rationale for emotional eating, there is some evidence that emotional eating is attributed to positive emotions and experiences such as joy and celebration (Canetti, Bachar, Berry, 2002; Ganley, 1989; Macht, 1999).

According to a 2012 study by Hernandez-Hons and Woolley, emotional eating may also be used to compensate for an emotional void. For example, one participant described emotional

eating with the following, ‘‘It’s like so good and I’m so happy to be sitting right here eating this ‘Chunky Monkey’ and nothing else matters, you know? When eating makes me feel better emotionally, that’s what I describe as emotional eating’’ (p. 593). Study participants also described food as a distraction, a way to bring back memories, as well as a defense.

Emotions that follow emotional eating often include feelings of guilt and shame (Bennett, Greene, & Schwartz-Barcott, 2012; Bruch 1973; Dube, LeBel, Lu, 2005; Hernandez-Hons & Woolley, 2012; Snoek, Engels, Janssens, & van Strien, 2007). Further, feelings of guilt occurring during emotional eating as opposed to after have been labeled as “consumption guilt" (Kivetz & Simonson, 2002). Guilt and shame have also been found to occur when eating in public, especially for overweight emotional eaters. For example, emotional eaters reported feelings of being watched and judged by others regarding what they eat or the foods that they purchased bringing up feelings of shame (Hernandez-Hons & Woolley, 2012).

Additionally, a 2010 study (Zysberg & Rubanov) found a link between emotional eating and lower emotional intelligence. The term emotional intelligence refers to the ability to functionally accommodate and adapt to internal and external condition by identifying and processing complex emotions. Lower levels of emotional intelligence are linked to a decreased ability to cope with stressors and emotions (Mayer, Caruso, & Salovey, 1999; Zysberg & Rubanov, 2010).

Emotional eating as affect regulation. Affect regulation is based on the principle that individuals will act to preserve or alter the experience of perceived negative or positive states (Gross, 1998). Considering emotional eating, the negative emotions and experiences mentioned above are regulated by eating. Indeed, studies have overwhelmingly found that emotional eating is a form of affect regulation (Andrade, 2005; Bohon et al. 2009; Brown et al., 2009; Ganley,

1989, 1988b; Gross et al., 2006; Heatherton & Baumeister, 1991; Macht, 2008; Martin 2001; Spoor et al., 2007; Van Strien et al., 1986). The term affect refers to the climate of feelings connected to mood and emotion (Larsen, 2000). For example, if a person is experiencing a negative emotion or mood, the feeling might be distress. The individual may then attempt to alter the mood or emotion based on the feeling of distress. This is called affect regulation. In regard to emotional eating, studies have found that affect regulation is achieved by the consumption of calorie dense food in order to ameliorate negative emotions. For example, eating may provide a distraction, bringing relief from self-awareness and critical self-thoughts (Heatherton, Herman & Polivy, 1991). In addition, affect regulation often occurs during times of stress and can lead to a lack of impulse control. Such behaviors do not occur solely with food but also other self-regulatory restraints such as smoking, shopping, gambling, drugs, and sex. In these instances, impulse control based on long term goals such as weight loss can be disregarded in favor of an immediate reward. Indeed, studies have found that when individuals are under emotional distress, such as anxiety or depression, priority is shifted to short-term gratification and escape from self-awareness. In a 1981 emotional eating study, Edelman found that seventy percent of his test subjects who self-identified as emotional eaters used food to alter their emotional states. Another emotional eating study conducted by Swanson and Dinello (1970), found that subjects reported that, "they obtained some relief from anxiety and frustration by eating" (p. 123). In addition, the use of food to alter negative affect was found in nine other studies and identified as a key causality in emotional eating (Ganley, 1989).

The difference between emotional eating and binge eating disorders. It is well documented that emotional eating plays a role in the binge eating behavior in both Binge Eating Disorder (BED) and Bulimia Nervosa (BN) (Ouwens, van Strien, van Leeuwe, & van der Staak,

2009; Stice, Shah, & Nemeroff, 1998; Wolfe, Baker, Smith, & Kelly-Weeder, 2009). However, it is important to make a distinction between emotional eating as an atypical eating behavior and binge eating disorders such as BN and BED (van Strien, 2002). For example, both BED and BN are characterized by a greater degree of severity of mental and physical impairment than emotional eating (American Psychiatric Association, 2013; Ricciardelli & McCabe, 2004). BN and BED are both characterized by diminished social functioning, lower life quality, greater severity of psychiatric comorbidity, and overall poorer physical health (American Psychiatric Association, 2013; Hudson et al., 2007; Wilfley, Schwartz , Spurrell, & Fairburn, 2000; Yanovski, 2003). While emotional eating is associated with distress, frustration, and inability to maintain weight loss, the level of impairment is not as chronic or pervasive (Grant & Boersma, 2005; Sarlio-Lahteenkorva, 1999; Stice et al., 2002; Van Strien et al., 2005). Additionally, those diagnosed with binge eating disorders have been found to exhibit a greater degree of loss of control over eating behavior (Gold, Frost-Pineda, & Jacobs, 2003; Ricciardelli & McCabe, 2004). A 2004 study also found that those with binge eating disorders were less able to engage in foresight (Ricciardelli & McCabe). Further, those diagnosed with binge eating disorders show an overall greater preoccupation with food (Crow, Agras, Halmi, Mitchell & Kraemer, 2002;. Johnson, Spitzer, & Williams, 2001; Wilfley et al., 2000). For example, a majority of individual diagnosed with BED show symptoms of food addiction (Gerhardt, et al., 2011). Food addiction is characterized by diminished control during food consumption and the inability to reduce the amount and frequency of consumption, regardless of negative consequences (Davis & Carter, 2009; Gerhardt, Corbin, & Brownell, 2009; Gold et al., 2003). Additionally, food addiction has been found to be similar to substance addiction and in some cases can be quite severe. For instance, a recent study (Gerhardt et al., 2011a) found that those with BED who scored higher on

a food addiction scale showed similar neural patterns of disinhibition to that of cocaine users. In the case of food addiction, eating may not occur as a reaction to negative emotions but rather neurological impulses. Those who have food addiction tend to consume more food than individuals who eat emotionally (Gerhardt et al., 2011b). Ultimately, while there may not initially appear to be great distinction between emotional eating and binge eating disorders, such as BED and BN, it is clear that significant characteristics and impacts of each differ considerably (Heatherton, Striepe, & Wittenberg, 1998).

Significance

Emotional eating is a common phenomenon and while techniques and interventions, as discussed below, have been identified and proposed, little research could be found on how or if these recommendations are utilized or applied by therapists. For example, most studies on emotional eating focus on the causation rather than treatment application. Concurrently, there is a significant amount of popular literature generated on the topic of emotional eating. For example, a keyword search of "emotional eating" on the popular retail website Amazon.com yields thousands of results largely under the subject heading of "self-help" and "weight loss". Yet, little academic research could be found regarding how emotional eating is best treated in a clinical setting. Additionally, there is a lack of information about how therapists work with clients as well as conceptualize and apply treatment to emotional eating not diagnosed as BED or BN. Therefore, it is important fill this gap in literature by identifying salient themes and recommendations regarding treatment for emotional eating. By compiling this data via consensus from experts in the field, the hope is to create informed treatment recommendations and direction for future research in order to both increase and enhance therapeutic and research knowledge with the goal of better serving clients.

Rationale for Methodology

This study was conducted using the Delphi research method. The Delphi method is a valuable research tool for researchers who are, exploring emerging topics and theories, generating recommendations for the development of future interventions, and closing the gap between practice and research. The Delphi method is especially salient as it utilizes expert opinion via structured communication in order to reach consensus. It additionally allows researchers to draw from a diverse field of both experience and knowledge. Further, the use of collective input based on expert opinion has been found to generate better understanding of specific or understudied topics (Stone Fish & Busby, 1996). Therefore, the Delphi method is a useful and practical application for generating greater insight regarding the understudied topic of therapeutic invention for clients who emotionally eat. Through this method the goal will be to highlight key and effective treatment interventions from those who understand it best in order to create better informed recommendations for treatment and future research.

Theoretical Frameworks: Emotional Eating Theory, Affect Regulation Theory, and Smart Practice

Emotional eating theory was original proposed by Bruch (1973) and is related to psychodynamic thinking. Bruch's emotional eating theory operates under two main assumptions. The first assumption is that negative emotions increase desire and cravings to consume food which is then followed by eating. The second assumption is that by eating, the intensity of negative emotions is reduced. This is similar to the tenets of learning theory which states that negative emotions create a classically conditioned response of food craving that are then followed by an operant response of food consumption which then lessens negative emotions, further reinforcing eating as a way to cope with negative emotions when they arise (Booth,

1994). During the past 40 years numerous studies have found evidence supporting the validity of this theory (Agras & Telch 1998; Booth, 1994; Herman & Polivy, 2005; Macht, 2008; Slochower ,1976; Slochower & Kaplan, 1980).

It is also important to note the relationship between emotional eating theory and affect regulation theory. Affect regulation theory states that emotional stimuli are processed reflexively and responded to via bodily-based survival mechanisms such a fight, flight, or flee (Schore, 2001). This is also the premise of emotional eating theory, however in emotional eating theory, the self-protective response is specifically defined as food consumption (Bruch, 1973). Affect regulation theory also elaborates on the mechanisms for unconscious reactions by exploring through neuroscience the location of emotional stimuli in the brain (Schore, 2001). This theory also builds upon attachment theory surmising that early childhood relationships later shape one's reaction to emotional stimuli (Schore, 2008).

Smart practice research and the delphi method. Smart practice research is based on the theoretical assumption that rather than placing abstract suppositions on what might work to achieve a desired resulted we should seek to better understand and develop what is currently being utilized and proven to be effective. Smart practice is also known as best practice (Veselý, 2011). However, this researcher employed the term "smart practice" in agreement with Barrdach (2000), who felt the title "best practice," could be construed as misleading as it is not feasible to fully utilize exemplars from all possible options. The term smart practice acknowledges that concepts put forth are smart and interesting and deserving of consideration. The primary goal of this premise involves careful analysis and dissemination of that which already works. According to Overman and Boyd (1994), this consists of "the selective observation of a set of exemplars across different contexts in order to derive more generalizable principles and theories" (p.69).

The goal is to find exceptional exemplars that already are in existence and better understand their role and why they work. Smart practice research is also a way of thinking that emphasizes continuous learning, feedback, and reflection on what does and does not work and why it does not work (Stenström & Laine 2011; Tuominen, Koskinen-Ollonqvist, & Rouvinen-Wilenius, 2004). Smart practice operates by seeking out functionality in terms of what works fully or partially and what has worked in similar circumstances and is transferrable. The end result is the identification of reliable and innovative methods that can be transformed or extrapolated into new practices (Stenström & Laine, 2011).

The philosophical and theoretical assumptions of the Delphi method are in line with those of smart practices research. As mentioned above the Delphi method is informed by the consensus of expert panelists or exemplars. The theoretical and philosophical underpinnings for the Delphi method arise out of the notion that "two heads are better than one" and that truth is relative. The assumption is that the beliefs of a single person are not isolated and that the contribution of multiple individuals is vital for gaining context and constructing reality. Therefore, in the dDelphi method the contributions of each participant are both acknowledged and crucial to the study (Guba & Lincoln, 1994). In this regard, the Delphi method is considered a post-modern approach. Additionally, as a qualitative research design the Delphi method favors subjectivism and interpretation (Stone Fish & Busby, 2005). This is similar to smart practice which is also qualitative in nature and accepts abstraction rather than certainty (Bardach, 2000).

Purpose of the Study

The purpose of this study is to identify key therapeutic elements through a review of literature and expert consensus regarding the treatment for emotional eating. These data will then

be used to generate treatment recommendations for clients who engage in emotional eating as well as areas of future research.

Chapter II: Literature Review

Emotional Eating Behavior

Studies conducted on individuals who engage in emotional eating indicate several patterns within this behavior. For example, they found that patterns of emotional eating are episodic, based on stress, emotional strife, and interpersonal challenges (Bennett, et al., 2012; Ganley, 1989; Polivy et al., 1994)**.** Further, restrictive eating or dieting may also contribute to this episodic pattern. This is because individuals refrain from indulgences brought on by emotional eating for periods of time and then may have brief periods of relapse (Ouwens, van Strien, & van der Staak, 2003). This pattern, explained by dietary restraint theory (Polivy & Herman, 1985), is believed to occur when emotional eaters, who engage in restrained eating or chronic dieting, become rigid and hyper-focused on what they eat in order to avoid gaining weight. However, strong emotions can result in diminished rigidity and hyper focus resulting in overeating. Loss of control of eating can then result in further negative emotions such as shame (Blair, Lewis, & Booth, 1990; Canetti, et al., 2002; Polivy & Herman, 1985).

Isolating and secretive behaviors have also been reported. A 1981 study, conducted by Hudson and Williams asked participants to describe their emotional eating behavior. Words such as sneak, hide, alone, and secretive were often used. Part of this pattern may have to do with the fear of social ostracism and judgment. These feelings of being judged have been reported to lead to even further isolation and stifle support seeking and intensifying secretive eating behavior. Additionally, a 2012 study (Hernandez-Hons &Woolley) found that half of participants who engaged in secretive eating started in childhood and continued into adulthood. Participants in the study reported that secretive eating in childhood made them feel that they could have the power that their parents once had over them, such as controlling and monitoring the food they ate. This

feeling of gaining power continued into adulthood with romantic relationships. Participants identified this behavior as a form of rebellion and a release for emotional distress. In adulthood, secretive eating was also employed in order to avoid judgment and criticism, yet it further reinforced feelings of being isolated and unsupported. For example, some participants reported altering their eating habits while in public in order to avoid judgment. Ultimately, feeling socially judged, participants reported themselves as less likely to seek social support when upset.

In addition to emotional eating being episodic and secretive, it may be centered on specific foods. A 2003 study by Wansink, Cheney, and Chan, found that there were differences in the types of food consumed by men and women. Their study found that men preferred non-sweet meals and that women preferred sweet snack foods. A 2000 study, (van Strien) found that negative emotions were associated with increased consumption of ice cream in women without eating disorders.

In terms of food quantity consumed, emotional eating is often thought to occur as a binge eating episode, which is defined as the consumption of a large quantity of food in a short period of time. However, a study found that this is not always the case and that emotional eating can occur as snacking or indulging in so called “forbidden foods,” or food items that an individual is attempting to avoid (Wilson, et al., 1993).

Finally, recent research by Kemp, Bui, and Grier (2011) found that prior to eating, emotional eaters often engaged in ruminative or repetitive thinking and prefectural thinking, defined as stimulation brought on by thinking about future events. Pre-factual or anticipatory thinking about eating and certain types of food included themes of self-justification and a tendency to ignore food nutritional and content labels. It is also believed that ignoring nutritional labeling is a tactic in order to avoid consumption guilt (Hernandez-Hons & Woolley, 2012). This

seems to be followed by rumination about a certain type of food such as sweets or chips (Hernandez-Hons & Woolley, 2012; Kemp et al., 2011). In terms of rumination, another study found that for emotional eaters, certain foods can become "seductive" and individuals were not able to avoid consuming them if they were available (Hernandez-Hons & Woolley, 2012). Informants in the 2012 study were also found to ruminate about distress and negative emotions. A focus on negative thoughts was found to lead to a pattern of further fantasizing or ruminating about how food can be used to escape and distract from problems (Kemp et al., 2011).

Influences on Emotional Eating

Research suggests a link between family dynamics and experiences in childhood with emotional eating (Topham et al., 2011). The belief is that early childhood environment creates a schema based on family beliefs, sociological and cultural norms, and rules for food consumption. This schema can have a powerful effect on the meaning of food for certain individuals (Herman & Polivy, 2005; Herman, 1996). For example, studies have found that parental consumption of food is often modeled by children (Birch & Fisher, 1998; Whitaker et al., 1997). A study that included 854 subjects found that parents that were over-weight tended to have over-weight children. This led the researchers to hypothesize that eating style and obesity can be passed down from generation to generation (Whitaker et al., 1997). In this regard children whose parents eat emotionally may also model this behavior. For example, a 2002 study (Wardle, Sanderson, Guthrie, Rapoport, & Plomin) found that mothers who eat emotionally have a tendency to feed their children based on emotional impulses. Children have been found to not only model both parental food consumption and choice (Birch & Fisher, 1998; Wardle, Guthrie, Sanderson, Birch, & Plomin, 2001) but also parental attitude and rationale for consuming food (Brown & Ogden, 2004). Additionally, parents may contribute to emotional eating by rewarding children

with food for good behavior or to console them. This process creates a direct link between food and being rewarded, creating a system for emotional eating and affect regulation. Indeed, research has found that those children who were given food either as a reward or conciliation were two and a half times more times likely as young adults to engage in emotional eating (Brown et al., 2009).

In adulthood, food can also trigger positive memories of childhood and can bring comfort via nostalgic reminiscing. Indeed, these types of foods dubbed "comfort foods" were consumed in order to sooth and reassure when emotional eaters were seeking "solace" and "wellbeing" (Herman & Polivy, 2005; Hernandez-Hons &Woolley, 2012; LeBel, Lu & Dubé, 2008; Pelkman Phole, & Navia 2007). This type of nostalgic bonding with food may then generate comforting memories and may then be used to lessen feelings of loneliness and sadness (Hernandez-Hons &Woolley, 2012; Schindler & Holbrook, 2003).

There is also a positive connection between parental pressure to eat and emotional eating in children and adolescents (Carper, Fisher, & Birch, 2000). Further, children and adolescents who perceive higher maternal psychological and behavioral control regarding their eating behavior were found to engage more in emotional eating (Snoek at al., 2007).

Finally, a 2012 study by Hernandez-Hons and Woolley identified a pattern of unsafe relationships with attachment figures, especially during childhood, that continued into adulthood. They found that difficulty with attachment, especially in romantic relationships in adulthood, led to a coping pattern of emotional eating in order to address a lack of satisfying emotional connection. The study found that all participants had experienced rejection in their attempts to gain emotional connection, leading them to believe that attempting connection with others was too risky and they sought out food in order to fill this "void". This pattern is consistent with

findings of another study, where loneliness and lack of support was a theme for participants who coped via emotional eating (Grant & Boersma, 2005). For example, participants in the 2012 study (Hernandez-Hons & Woolley) who had insecure attachment tended to generalize this insecurity to relationships as well as other areas of their life. As one participant stated:

> As far as with other people, the fear of rejection—I always have something in the back of my mind. I think that person doesn't like me, they just pretend to like me. I've always been that way. I've always been reserved and holding back and making sure that people like me, which isn't always easy. People don't always want to come out right away and [say] ''I love ya.'' Food is never rejecting. You know, it's always safe and consistent; it's always going to be there. It's always my comfort zone. (p. 596).

The 2012 study purported that the fear of emotional closeness is so great emotional eating becomes a protective and comforting measure. The belief is that food will always be a constant and will never abandon or reject. In this study, emotional eating was reported to be utilized, especially regarding romantic relationships, as an escape from dissatisfaction as well as a way to prevent others from getting too close. For example, one participant stated:

> 'That's one thing that stops me from doing anything about my weight. I'm so comfortable with it and I'm just afraid to give up my excuse. Well, I can't get a boyfriend because I'm too fat. Now it becomes, I can't get a boyfriend because people don't like me. It's part of my defense (p 597).

The study reported that participants used food in order to cope with insecure attachment and viewed eating as a way of coping and protecting themselves during times of tension, anxiety, and isolation (Hernandez-Hons & Woolley, 2012).

In addition to family environment, it has been documented that eating behavior is linked to social norms and expectations (Bekker et al., 2004; Foy, 2000; Kemp et al., 2011). For example, numerous social activities such as parties and holiday events are centered on food. Studies have found that often these activities along with expectations to indulge in eating increase the likelihood of emotional eating (Patel & Schlundt, 2001). One study found that emotional eaters whose family and friends engaged in emotional eating together, further felt that this behavior was normative (Kemp et al., 2011), as pleasure and acceptance can be a characteristic of communal eating (Patel & Schlundt, 2001). As one participant in a 2011 study (Kemp et al.) explained, "My sister is my eating buddy. I do all the cooking, invite her over and we eat together." (p. 6). In this way eating is seen as a celebration and increases feelings of warmth and connection which further increases an association between acceptance and food (Grant & Boersma, 2005; Hernandez-Hons &Woolley, 2012). In the 2011 study (Kemp et al.), food was also found to bring a sense of security. For example, one participant explained that in her culture having enough food and being able to feed her family produced feelings of safety, success, and comfort. These feelings can further solidify the belief in food as a comfort, reward, or nostalgic memory, leading to an increased tendency to use food in order to recapture these feelings during times of emotional stress (Kemp et al.).

Further, in social gatherings emotional eaters are also more likely to over consume food. Studies have found that emotional eaters tend to eat more when they are in groups, especially when they are eating with family and friends. For example, in social environments non-emotional eaters indicated that they were able to control the amount of food they ate. Emotional eaters, however, tended to eat 40 to 50 percent more than non-emotional eaters (Redd & de Castro, 1992).

Affect Regulation Overview

Affect or emotional regulation is defined as the "processes by which individuals influence which emotions they have, when they have them, and how they experience these emotions" (Gross, 1999, p. 275). Adding to this definition, Thompson (1994) states that "affect regulation consists of the extrinsic process responsible for monitoring, evaluating, and modifying emotional reactions, especially the intensive and temporal features, to accomplish ones goals" (pp. 27-28). Affect states can be both positive and negative and affect regulation, put very simply, tends to favor maintaining positive states while repairing negative (Forgas, 2006). In regard to this process, individuals will assess their current state of affect and compare it with a desired affective state. For example, if they are feeling sad they will compare this against feeling content. If a discrepancy is found between what an individual experiences and what they desire to experience, a regulatory attempt is made (Augustine & Hemenover, 2009). These regulatory attempts can be made in the anticipation of an emotional response or after the fact (Gross, 1999) and are believed to occur at both the subconscious and conscious level (Fongay, Gergely, & Jurist, 2003). Further, affect regulation includes four overlapping constructs including coping, emotion regulation, mood regulation, and psychological defenses. In terms of affect regulation, coping focuses on dealing with alleviating negative affect, with emotion and mood regulation being the "affects" that are altered. Psychological defenses are more aggressive and typically subconscious impulses, such as eating or drug use that are associated with negative affect (Gross, 2006). These constructs of affect regulation occur through both behavioral and mental strategies (Larsen, 2000). Mental strategies typically involve reassessing the situation and distraction or suppression of feelings and thoughts. Behavioral strategies are typically psychological defenses and can include seeking social support or avoidance such as walking away, isolating, and seeking

pleasurable or distracting activities such as eating or shopping (Thayer, Newman, & McClain, 1994). Overall, the mechanism for affect regulation is believed to be based on the basic need for survival. This is because a positive state or experience increases the likelihood of resiliency and adaptation to adverse and stressful conditions (Fredrickson, Tugade, Waugh, & Larkin, 2003).

Affect regulation theory identifies three key factors regarding an individual's process and outcome of self-regulation including belief about control, values and goals, and strategies and competencies (Mischel, Cantor, & Feldman, 1996; Mischel & Shoda, 1995). These three factors come into play throughout the life-span and are linked to a variety of complex interpersonal and neurobiological dynamics that are mostly shaped by social and developmental factors (Rothbart, Ahadi, & Evans, 2000). For example, it is widely believed that early childhood experiences, specifically attachment relationships, are a major factor in how one learns to regulate affect (Fox & Calkins, 2003, Goldberg et al., 1994; Schore, 2001). This is because, early attachment experiences are believed to be incorporated into an internal working model that heavily influences coping strategies for affect regulation (Schore & Schore, 2008). For example, Schore (2001) identified that in the early years, an infant's caregiver regulates the infants affect. If a caregiver is able to regulate affect within limits then the infant will be able to begin to develop their own adaptive affect regulation. However, this can only begin when the mechanisms for independent regulation have been developed sufficiently through attunement with a caregiver (Schore). If a caregiver or attachment figure is unresponsive and cannot help infants manage affect, then infants will develop their own system of affect regulation. For instance, when attachment figures are unresponsive to needs, a negative view of self and others is often generated and affect regulation strategies become avoidant and distant. This is also known as a secondary attachment strategy and can result in solitary coping in an effort to manage distress

(Bowlby, 1973; Shaver & Mikulincer, 2002). Distancing and isolating behavior is employed in order to avoid threats and suppress thoughts and memories that may trigger feeling of vulnerability (Shaver & Mikulincer,2002). Further, those with insecure attachment have been found to be more likely to develop unhealthy coping skills in order to ameliorate negative feelings related to their insecure attachment (Eggert, Levendosky, & Klump, 2007). Indeed, insecure attachment and distancing as a form of coping have been identified in those who engage in emotional eating (Hernandez-Hons &Woolley, 2012).

The regulation of affect can be both adaptive and maladaptive in nature (Gross, 2002; Skinner, Edge, Altman, & Sherwood, 2003; Thompson, 1994). It is believed that the most adaptive form of affect regulation is reappraisal (Gross, 2002). For example, if individuals facing traumatic circumstances are able to discover a "silver lining," as well as meaning, acceptance and gratitude, and advantageous counterfactuals such as feelings that an outcome could have been worse, were found to be better able to emotionally adjust and adapt (Gross). Further, reappraisal strategies such as seeking support and problem-oriented planning and action were found to increase self-efficacy regarding ability to regulate affect and increase overall feelings of well-being. Additionally, self-control is also considered to be another adaptive affect response, specifically during times of negative affect (Connor-Smith & Flachsbart, 2007). Self-control has been linked to dispositional happiness and is associated with greater self-acceptance (Páez et al., 2012; Tkach & Lyubomirsky,2006). Affect strategies that are based on acceptance and adjusting to an event, especially if strategies include mindfulness, have also been found to both lessen negative affect and reinforce positive affect (Aldao et al., 2010; Fredrickson, 2009).

On the other hand, maladaptive affect regulation such as suppression of thoughts and feelings through isolating and distraction have been found to prolong and intensify emotional

reactions (Barber, Bagsby, & Munz, 2010; Gross et al., 2006). For example, the process of suppression is believed to involve two counter thought processes, one revolves around changing affect and the others focuses on failure to achieve the preferred state of affect, which further exacerbates the negative emotional response (Lowenstein, 2009; Wegner, Erber, & Zanakos, 1993; Wegner & Wenzlaff, 2000). Suppression has also been found to decrease psychological well-being and is associated with lessening the ability to achieve adaptive goals such as seeking out social support. In addition to suppression, rumination or repetitive thinking that focus on negative feelings has been found to intensify negative emotions and has also been found to be a maladaptive form of affect regulation (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Compass, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001.)

Ultimately, which type of affect regulation strategy individuals utilize is based on what they feel will be most effective while avoiding those that have not worked in the past, which is often shaped by experiences with caregivers during early childhood (Schore, 2001).

Emotional Eating as Maladaptive Affect Regulation

Utilizing food in order to regulate affect is often considered to be maladaptive affect regulation. The rationale for this belief is that emotional eating is often used as a coping tool in order to suppress and distract from negative emotions as well as an escape from self-awareness.(Andrade, 2005; Bekker, Meerendonk, & Mollerus, 2004; Bohon et al. 2009; Brown et al., 2009; Ganley,1988; Gross et al., 2006; Heatherton & Baumeister, 1991; Macht, 2008; Martin 2001; Spoor et al., 2007; Van Strien et al., 1986). Further, using food to distract and regulate emotions has been found to be a both a deliberate and subconscious distraction-oriented behavioral strategy (Parkinson & Totterdell, 1999). Emotional eating is also related to a loss of impulse control which is symptomatic of an inability to adaptively self-regulate (Greeno &

Wing, 1994). Emotional eaters have also been found to demonstrate an avoidant attachment style which has been linked to the maladaptive affect regulation strategy of deactivation, whereby individuals suppress negative feelings and avoid others (Mikulincer, Shaver, & Pereg, 2003; Pietromonaco & Feldman-Barrett, 2000; Shaver & Mikulincer, 2002). Though these strategies may work in in the short-term, they have a tendency to increase negative mood (Cassidy, 2000). For example, a reciprocal and escalating pattern of negative mood within emotional eating has been found. Emotional distress results in consumption of food and isolation resulting in temporary relief followed by feelings of guilt, loneliness, and anxiety which then increases negative mood and consumption of food (Heatherton & Polivy, 1992). Additionally, by habitually escaping or avoiding emotions through eating individuals have been found to have greater difficulty in both identifying and describing emotions which can result in feelings of incompetence when it comes to adaptively regulating emotions (Spence & Courbasson, 2012). Finally, eating as an affect regulation strategy may undermine attempts to maintain long-term health goals and may thus causes emotional distress and negative health implications (Heatherton, Herman, & Polivy, 1991; Heatherton, Striepe, & Wittenberg, 1998; Kemp et al., 2011; Tice, Bratslavsky & Baumeister, 2001).

Treatment Recommendations for Emotional Eating

Emotional eating behavior has been connected with lower feelings of self-worth (Gross & Muñoz, 1995) and somatic illnesses (Gross & John, 2003). In addition, a persistent pattern of emotional eating has also been found to increase the likelihood of individuals becoming overweight and obese and as well as leading to more maladaptive eating behavior such as binge eating disorder and bulimia (Grant & Boersma, 2005; Grilo, Shiffman, & Wing, 1989; Reed,2013; Sarlio-Lahteenkorva, 1999; Stice et., 2002; Van Strien et al., 2005). Despite these

findings, minimal research on emotional eating in terms of specific therapeutic interventions could be found. However, the research that has been conducted on the phenomenon of emotional eating, defined largely in these studies as eating or overeating in response to emotion, has suggested a variety of interpersonal mechanisms that could be addressed in a clinical setting. For example, researchers have proposed that because emotional eating is related to maladaptive coping strategies therapeutic interventions should focus on increasing techniques for utilizing alternative coping options. This includes identifying self-criticism and replacing it with positive self-talk (Andrews, Lowe, & Clair, 2011; Kayman, Bruvold, & Stern, 1990).

Additionally identified, is the importance of increasing understanding of personal narratives in relation to food by examining the role food plays within in family and cultural background. The supposition is that by identifying and working to renegotiate schemas or personal narratives an individual could redefine his or her relationship with food as a coping tool (Bekker et al., 2004; LeBel et al., 2008). Research also suggests that better understanding of internal emotional processes and increasing levels of emotional availability might help open up possibilities for finding more adaptive coping techniques and increase self-efficacy and self-esteem (Foy, 2000; Kemp et al., 2011; Kidwell, Hardesty, & Childers, 2008).

Another treatment recommendation, especially salient to the role affect regulation in emotional eating, is the importance of addressing attachment style. A 2011 study found that addressing attachment, cultural, and interpersonal foundations helped clients better understand the impact and role of food and emotional eating in their lives (Hernandez-Hons & Woolley, 2011). In addition, it has been suggested that therapeutic intervention might focus on helping clients gain a better sense attachment security by facilitating the development of more adaptive

security centered strategies for affect regulation, such as seeking social support (Mikilincer, et al., 2003).

Currently the most researched technique to address emotional eating is mindfulness. In a study conducted on mindfulness and emotional eating in 2012, Pidgeon, et al., found that emotional eating was moderated by utilizing mindfulness techniques such as meditation. In addition, Manzoni et al. (2009) found that relaxation techniques and training that include meditation has proven to be useful in treatment of emotional eating in women during a short-term study. Further, it is believed that because emotional eating can be a form of escapism and can take place at both the conscious and subconscious level, increasing well-being though self-awareness can help individuals identify and address maladaptive affect regulation mechanisms (Gross, 1998). Preliminary research suggests that this can be accomplished by working to reinterpret the stimuli used to modify emotion in addition to increasing awareness and a non-judgmental stance towards emotional processes through the use of mindfulness techniques (Brown, Marquis, & Guiffrida, 2013). Mindfulness has been found to be especially salient as it focuses on being present with emotions rather than suppressing them (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Wupperman, Neumann, & Axelrod, 2008). It is also believed that mindfulness helps alleviate these conditions by focusing on acceptance and awareness of an experience without judging which in turn ameliorates negative emotions (Nyklicek, 2011).

In addition to mediation, mindful eating has also been found to increase “non-judgmental awareness” and better understanding of internal hunger cues and emotions for emotional eaters during food consumption or at food based events (Framson et al., 2009, p. 2). For example, mindful eating has been found to help improve feelings of satiety as well as identify but not

respond to non-biological hunger cues such as anxiety and boredom. The term mindful eating involves focusing on both taste and sensations of food while eating (Wansink, 2004).

In regards to therapeutic models and treatment plans, one study explored the effectiveness of addressing eating as affect regulation in persons with binge eating disorder. The study conducted in 2001, used Dialectical Behavior Therapy (DBT) to specifically target affect regulation in order to control binge eating episodes (Telch, Agras, & Linehan, 2001). DBT, which was first created to treat clients diagnosed with borderline personality disorder, focuses on teaching adaptive emotional regulation skills, behavioral analysis, and mindfulness training to increase awareness of emotions. Indeed this study showed promise in reducing binge eating behavior for a period of six months after treatment. However, the study was not able to identify specifically why DBT helped some clients refrain from binge eating episodes.

Ultimately, it is clear that there is a significant link between emotional eating and an increased consumption of food which has been linked to a higher risk of becoming over-weight or obese as well as developing eating disorders. Yet, there remains a deficit of detailed information regarding treatment specifically for emotional eating in a clinical setting. Given this information, there is a need to explore and identify essential elements for effective treatment of emotional eating.

Research Question

Given the recommendations from both a review of literature and a panel of experts, what are the recommended smart practices regarding treatment for clients who emotionally eat?

Chapter 3: Methods

Design of the Study

This study utilized the Delphi method in order to generate consensus regarding the best elements of therapeutic treatment for emotional eating. In order to generate informed consensus an expert panel of mental health professionals who specialize in emotional eating were given questionnaires specific to the topic of treatment for emotional eating. For this study, a modified Delphi method was used. Instead of the traditional three rounds of questionnaires, this study was comprised of two rounds. This decision was based on the exploratory nature of this study, time constraints, and to encourage greater panelist participation by reducing questionnaire fatigue and attrition. The first questionnaire was comprised of a demographic survey and an open-ended questionnaire. The questionnaire was designed to identify key characteristics and elements of therapeutic experience and treatment outcomes. Panelists were also given the opportunity to make statements regarding treatment recommendations derived from the literature review. During the second phase of the Delphi study, the researcher analyzed responses from the first questionnaire and then consolidated them in order to generate a list of best treatment practices to be evaluated via a Likert survey. The researcher also gave panelists an opportunity to comment or ask questions reading the recommended practices in questionnaire II (QII). This data was then analyzed statistically to identify essential and very important treatment recommendations in order to compile a list of smart practice recommendations for treatment (Stone Fish & Busby, 1996).

Delphi Panel Selection

Panelists are integral to the validity and credibility of the Delphi study, therefore careful panelist selection is critical (Stone Fish & Busby, 1996). Consequently, randomly selecting

panelists for a Delphi study is not appropriate (Ludwig, 1997) and thus characteristics and qualifications of desirable panelist were identified and selected by the researcher. For this study, panelists must have met the following criteria: (a) have conducted therapy with a client who has not been diagnosed with an eating disorder and has engaged in emotional eating during the past three years (b) be a licensed clinician with a qualifying degree (e.g. LMFT, LPC, LCSW, PhD or PsyD) and must have met at least one of the following criteria (a) have at least two years clinical experience treating adults who engage in emotional eating yet do not meet the criteria for an eating disorder (b) conducted a peer reviewed study on the topic of emotional eating (c) given lectures or trainings on the topic of emotional eating.

The researcher utilized the World Wide Web in order to identify potential candidates for this study. In particular, candidates were identified via their professional web page. The researcher specifically sought therapeutic professionals who offered treatment for emotional eating, ran groups for emotional eating, and provided writings and resources regarding this topic. The researcher also took note of the therapist's credentials to ensure that they met the requirement for degree and licensure. Identified potential candidates were then contacted via an e-mail that included the nature of the study, study criteria, unique identifier number, and a link to the first survey (Appendix A). In total, fifty therapists were contacted in this manner. Potential candidates were also contacted via both list serve and recommendations from other mental health professionals. The process involved an e-mail with study criteria asking that all those who met these criteria and desired to participate contact the researcher via e-mail. Those who responded with interest regarding participation in the study were then sent further information about the study including a unique identifier number and a link to the first survey. Through these recruitment methods, twenty potential panelists contacted the researcher. Ultimately, three of

these potential panelists did not meet the criteria for the study. Of the remaining seventeen potential panelists who met the study criteria, nine completed the first survey by the March, 26, 2014 deadline. Once the nine panelists had completed Questionnaire I (QI), the researcher reviewed their responses to certify that all study criteria requirements were met. Panelists were sent Questionnaire II (QII) on April 1, 2014 and all nine panelists completed the QII by the April, 7, 2014 deadline.

For a Delphi study, there is no set consensus in regard to the number of panelists required. Ludwig (1994) states, that the number of expert panelist in a Delphi study is "generally determined by the number required to constitute a representative pooling of judgments and the information processing capability of the research team." Due to the specificity of this study, the researcher sought seven to ten panelists resulting in a final number of nine panelists.

Delphi Procedures

As mentioned above, potential panelists were all sent an e-mail letter that stated the criteria for the study as well as a unique identifier number and link to the first survey. Panelists were informed that their unique identifier number was to ensure their confidentiality as well as to match data across questionnaires. This letter also indicated that the requirements for participation would involve completing two surveys and that the data from their responses would assist in identifying key concepts and processes for treatment guidelines. Panelists were also notified that there was minimal risk to participate in the study and that participation was completely voluntary; and they could drop out of the study at any time without consequence. Panelists were informed that the consent form was located at the beginning of the first questionnaire and consent was implied by completing this questionnaire (See Appendix B). The first questionnaire consisted of a demographic survey and an open ended questionnaire (Appendix C). Results from

the questionnaire were analyzed and assessed for themes used to develop the second questionnaire. A second e-mail letter was sent once the second and final questionnaire was generated (Appendix D). This letter let the panelists know that the second questionnaire was comprised of recommendations for treatment identified in the first questionnaire, as well as four demographic questions regarding treatment length and setting. The e-mail letter also provided a link to the second survey as well as the panelist's unique identifier number. Panelists were once again reminded of the minimal risk to participate in the study and that their involvement was completely voluntary. Panelists were also informed that they would receive a final copy of the results.

The second and final questionnaire consisted of a Likert style survey asking panelists to rate identified elements of treatment as well as respond to four demographic questions (See appendix E). Panelists were also given a final opportunity to comment on these elements of treatment recommendation.

Data Analysis

Questionnaire I

Data for Questionnaire I (QI) were analyzed via thematic analysis. The data from open ended questions were first read over several times to increase familiarization and grouped into themes. These themes were reviewed, and clustered into categories of treatment (Godfrey, Haddock, Fisher & Lund, 2006). Multiple coders were utilized to further categorize responses, search for patterns, identify themes, and eliminate like responses. The coders were careful to retain the original text provided by the expert panelists (Creswell, 2007). Additionally, as this study is exploratory and driven by smart practice which values the input of each participant, the

comments of each panelist were taken into consideration. The data collected in Q1, were used to develop QII which is comprised of more specific themes and pointed questions.

Questionnaire II

QII was comprised of 70 questions within four major themes and 12 sub-themes that arose out of the thematic analysis of QI. The nine panelists were asked to provide information regarding demographics of treatment which were analyzed by calculating the median and mean. Panelists were also asked to rate elements of treatment on a one to five Likert scale, with five being "should not be included," four being "unimportant," three being "do not know and/or not sure," two being "very important" and one being "essential." Panelists were also given the opportunity to comment after each subcategory. The data from the Likert questions were analyzed by calculating the median and interquartile range for each of the recommendations listed in QII. Thus, the median signifies the measure of importance for each recommendation depending on where it falls along the one to five Likert scale (Stone Fish & Busby, 1996; Stone Fish & Piercy, 1987). Further, in order to avoid potential confusion, the researcher inverted the numbers so that the higher numbers indicated greater importance. Therefore, a median score of 5.0 of higher indicated that the recommendation is essential. A median score of 4.00-4.99 indicated that panelists rated the treatment recommendation as very important. A median of less than 4 resulted in the recommendation not being included in the final results.

The interquartile range (IQR) provided information regarding the variability of responses and signified a statistical agreement as it represents the range in the middle half of responses. Therefore, a smaller interquartile range denotes a higher consensus whereas a higher integer indicates a lower consensus. The IQR was calculated utilizing the formula IQR = x_U - x_L,

wherein x_U indicates the upper quartile and x_L indicates the lower quartile. For this study an interquartile range (IQR) of 1 or less indicates consensus.

Finally, any commentary by panelists was analyzed by multiple coders and utilized to provide further input, detail, and context regarding panelist's rationale for the rating of treatment recommendations (Godfrey et. al., 2006).

IV. Results

Expert Panel Demographics

The panel was comprised of eight females and one male from diverse clinical backgrounds, theoretical orientations, experience, and settings. The panelists ranged in age from 35 to70 with a mean age of 56.66. Professionally, there were four panelists with Masters of Social work degrees (MSW), one Masters of Addiction and Mental Health (MA, CAAC), one Masters of Psychiatric Counseling (MA) and Nutrition (MS), one Psychiatrist (MD), one Masters of Marriage and Family Therapy (MFT), and one Psychologist (PsyD). The length of time panelists have treated clients with emotional eating ranged from seven to 25 years with a mean of 16.44 years. Demographics pertaining to age, number of years licensed, and number of clients and years treating emotional eating can be seen in Table 1. Regarding the use of therapeutic models, panelists indicated utilizing twelve different therapeutic modalities. See Table 1. In terms of therapeutic environment, seven of the practitioners saw clients individually in a private practice setting. Six practitioners indicated that they offered group therapy for emotional eating. Panelists' therapeutic environments are listed in Table 2. The demographic survey also found that four therapists had given presentations and workshops on emotional eating with topics related to understanding emotional eating, managing holiday food, chronic overeating, body image, relationships with food, and food boundaries (Table 2). Additionally, two panelists had received specialty training including nutrition, mindfulness, and cognitive behavioral therapy. See Table 2.

Table 1
Expert Panel Demographics

Panelist	Gender	Age	Degree	Number of years licensed	Number of years treating clients with emotional eating
1	F	55	MSW	24	10
2	F	68	MA CAAC	7	7
3	F	50	MS MA	10	25
4	F	61	MSW	12	15
5	M	65	MD	36	10
6	F	51	MsC	7	7
7	F	70	MFT	21	18
8	F	55	MSW	27	17
9	F	35	PsyD	4	10
		Mean 56.6 Median 55		Mean 16.44 Median 12	Mean 13.22 Median 10

Table 2
Expert Panel Demographics

Panelist	Therapeutic setting	Therapeutic modality	Number of lectures or trainings given on emotional eating	Specialized training related to emotional eating
1	Private Practice Individual therapy Some Group Therapy	Cognitive Behavioral Therapy	8	
2	Private Practice Gestalt Institute Individual Therapy Group Therapy	Gestalt Cognitive Behavioral Therapy Techniques	2	
3	Private Practice Individual Therapy Group Therapy	Internal Family Systems		
4	Private Practice Individual Therapy	Interpersonal Therapy	2	Registered Dietitian
5	Private Practice Individual Therapy	Cognitive Behavioral Therapy		
6	Private Practice Individual Therapy Group Therapy Intensive Weekend Therapy	Motivational Interviewing Rapid Resolution Therapy Cognitive Behavioral Therapy Brief Solution Focused Therapy		
7	Private Practice Community Mental Health Agency Individual Therapy Group Therapy	Emotion Focused	2	Trauma resolution Cognitive restructuring Mindful meditation
8	Private Practice Individual Therapy Group Therapy	Emotion Focused Cognitive Restructuring Somatic Integration Social Support Connections		
9	Private Practice Clinic Individual Therapy	Long Term Psychotherapy		

Client Demographics as Reported by Expert Panelists

Panelists were asked to report for clients regarding gender, age, number of sessions, co-existing conditions, and rationale for seeking therapy. Panelists indicated that they treat women more often than men and their ages ranged from 18 to 72 years old. Six panelists reported, that on average, the number of sessions ranged from three to 72 with a mean of 26.22. Panelists indicated that clients often report or present with anxiety and depression. Depression was listed by seven panelists and anxiety was listed by six. Other conditions or symptoms included impulsivity, being overweight, and past trauma. See Table 3 for a full list of co-existing conditions or symptoms. Three panelists reported that clients sought therapy because they could no longer control their eating behavior on their own. Four panelists reported that clients came to therapy because they wanted to lose weight. One panelist stated that the client was referred by a general practitioner and one panelist reported that group therapy clients were seeking support, acceptance and guidance. For the list of client rationales for seeking therapy see Table 3.

Table 3
Client Demographics

Co-existing Conditions	Number of times indicated by panelist	Feelings and Emotions associated with emotional eating	Number of times indicated by panelist	Rationale for seeking therapy	Number of times indicated by panelist
Depression	7	Anxiety	5	Want to lose weight	4
Anxiety	6	Shame	4	Can't control eating on their own	3
Impulsivity/Impulse control	2	Boredom	2	Seeking support, acceptance, and guidance (group therapy)	1
Overweight/Obesity	2	Frustration	2	N/A Already engaged in the therapeutic process	1
Trauma	2	Loneliness	2	Increase feelings of self-worth	1
Adjustment Disorder	1	Sadness	2		
Bulimic Behaviors: over exercising/perfectionism	1	Anger	1		
Borderline Personality Disorder	1	Guilt	1		
Obsessive compulsive disorder	1	Self-Doubt	1		
Health Issues (Unspecified)	1	Fear	1		
Child sexual Abuse	1				
PTSD	1				
Compulsive shopping	1				
Axis II	1				
Intellectual Disabilities	1				
Major Medical Axis III	1				
Mood Disorder (not specified	1				

Results of Questionnaire I

Questionnaire I asked panelists open-ended questions regarding characteristics and recommendations for treatment (Appendix B). Panelists identified key elements of working with clients who engage in emotional eating. They included their perspective on emotional eating as affect regulation, their recommendations and guidelines for treatment, and their opinion on recommendations for treatment found in the literature review. Each panelist provided both long and short responses that varied in length from one or two words to several paragraphs. From the analysis of these responses, 70 questions were generated under four main themes and 12 sub-themes. Four main themes identified were:(1) discussing emotional eating and the therapeutic process and obstacles with clients, (2) therapeutic elements of individual therapy, (3) therapeutic elements of group therapy and, (4) additional resources. Under the therapeutic elements of individual therapy eight subthemes were generated: (1) addressing emotional eating as affect regulation, (2) identifying alternative coping mechanisms, (3) increasing emotional awareness, (4) understanding personal narratives and history regarding food, (5) identifying and interrupting ruminative and repetitive thinking about food, (6) increasing mindfulness, (7) addressing external and behavioral concerns, (8) addressing co-existing conditions. Listed below are themes along with detailed results from QI, and the development of questions for Q2.

Theme I: Discussing emotional eating, therapeutic process, and obstacles with clients

Discussing emotional eating with clients. Eight panelists identified that their clients had sought therapy specifically to address emotional eating and had brought up the subject. However, three panelists identified that they had been the ones to bring up emotional eating with their clients. As panelist 1 explains,

> The therapist might raise the issue of emotional eating if it is apparent. Most clients are so hopeless about it that they don't even think to mention it as a therapeutic issue when they go to a counselor, unless that counselor has been selected specifically for emotional eating work.

Further, three panelists identified that going slowly may be a good practice. For example, when asked how the topic of emotional eating was approached panelist 3 stated, "slowly and carefully," and went on to explain, "If done too quickly, clients can be left feeling as if they will have no way to cope with uncomfortable feelings. They will not give up the eating for affect regulation."

In addition, panelist 5 cautioned about possible countertransference regarding the therapist's physicality:

> For most of my practice I was 100 lbs. overweight and I am a man. While all of my patients claimed it didn't make a difference, I asked. I have to wonder. However, the one thing that came up repeated(ly) was that what made the difference for them was they felt they could trust me. Once they came to accept I was nonjudgmental they were willing to work seriously on the food issue. The trust issue was mostly a transference issue that had to be interpreted.

An additional theme included normalizing the prevalence of emotional eating behavior in order to reduce shame. For example panelist 1 stated that this was addressed, "through education and population statistics that help client(s) see this as a public health issue rather than as a personal failing."

The therapeutic process and obstacles. In regard to addressing therapeutic obstacles, several themes arose concerning psychoeducation about emotional eating, behaviors and attitudes that may lower feeling of self-efficacy, understanding the nature of the therapeutic process, and ambivalence towards change. In regard to the therapeutic process, panelist 3 explained, "[clients have an] overall, willingness to address issues, but not necessarily to take action to change. [They] get discouraged because rarely is there a 'quick fix'." Similarly, regarding ambivalence, panelist 1 stated, "Ambivalence is very high. They desperately want emotional freedom from eating, but almost as desperately want to hang onto the eating, giving it credit for emotional respite that it never truly delivers."

Theme II: Therapeutic Foundations of Individual Therapy

Nine sub-themes were identified regarding therapeutic foundations. These include:(1) addressing emotional eating as affect regulation, (2) identifying alternative coping mechanisms, (3) increasing emotional awareness, (4) understanding personal narratives and history regarding food and eating, (5) addressing attachment injuries and past trauma, (6) identifying and interrupting ruminative and repetitive thinking about food and eating, (7) increasing mindfulness, (8) addressing external and behavioral concerns, and (9) addressing co-existing conditions.

Emotional eating as affect regulation. All panelists agreed that emotional eating was a form of affect regulation. Three panelists indicated that they addressed affect regulation by helping clients understand how it impacted their eating behavior. Panelist 6 stated, "eating keeps mind and body busy to numb pain." Panelist 1 further explained, "it's an attempt at affect regulations, and part of the tx (therapy) is helping clients to see how ineffective it really is in this capacity. Short-term illusory relief in exchange for chronic emotional distress is exacerbated by the eating." Panelist 6 also stated, "I must educate, instruct, and guide client to feel without

numbing/distracting with food." In addition, three panelists stated that they addressed negative emotions that were the underlying cause of affect regulation. As panelist 3 explained, "I work with clients to heal the reason for the "negative" emotions so affect regulation does not need to occur thus stopping the emotional eating."

Identifying alternative coping mechanisms. In terms of identifying alternative coping mechanisms, eight panelists reported this was a part of treatment but not necessarily the main focus. Two panelists listed specific alternative coping mechanisms such as developing a support system or coming up with a plan or strategy to manage triggers. Two panelists felt it was more important to focus on coping rather than addressing past pain and trauma. For example, panelist 1 stated, "the greater focus is on what to do and how to cope now." In addition, panelists were also asked about patterns and triggers. Six panelists identified that this was addressed. Two panelists stated that this was something that clients worked on with a nutritionist. Panelist 2 identified that, "some are unaware of less obvious trigger foods (or trigger people, events), and what goes along with that."

Increasing emotional awareness. Seven panelists identified increasing understanding of internal emotional processes as a component of treatment. In addition, all panelists stated that they addressed feelings of guilt and shame with their clients. Two panelists offered suggestions and techniques that have helped their clients increase emotional awareness such as teaching emotional language, identifying where emotions occur in the body, and journaling.

Understanding personal narratives and history regarding food. Seven panelists reported that understanding personal narrative and history regarding food is a component of their therapeutic process. Two panelists indicated this is essential, while two others stated it helped to

provide context to emotional eating behavior and triggers. In addition , panelist 7 suggested that clients use a food journal to better understand narratives that occurred before eating.

Addressing attachment injuries and past trauma. All panelists identified addressing attachment injuries as part of treatment. Three felt this was an important part of ongoing therapy. Five panelists felt it was less essential but it did provided context or served educational purposes. In addition, past trauma and PTSD were brought up by three panelists, see Table 4. For example, panelist 8 identified, "For this client emotional eating may have been a behavioral response to the PTSD and sexual abuse."

Identifying and interrupting ruminative and repetitive thinking about food. Six panelists identified that they addressed ruminative and repetitive thinking with different degrees of emphasis. Additionally, panelist 2 cautioned that, "Yes. That's a first step - but without a next step and something to do immediately after (some action to take, whether it's to write/journal, phone someone, walk, breathe, draw, distract themselves) it becomes awareness."

Increasing mindfulness. Seven panelists indicated that increasing mindfulness was part of their treatment for emotional eating. Panelists specifically identified that mindfulness helped clients to get in touch with the body and emotions, increase self-compassion, and slow down eating. Further, meditation and mindful eating, specific techniques found to increase mindfulness, (Manzoni et. al. 2009) were also assessed. Four panelists indicated that some of their clients were not interested or motivated to utilize mediation. Panelist 1 stated, "It's a great idea but not a good fit for everyone. I encourage those who feel open toward it, and help others to find methods that fit them better." In regard to mindful eating, five panelists indicated that they used this as part of treatment and indicated that it slowed down eating. Four panelists stated that they did not utilize mindful eating. Two panelists identified that their clients were not

interested in or motivated to utilize this technique. For example, panelist 2 stated, "only if clients are willing and interested. It is not a cure. The people I see who eat emotionally don't usually do it out of hunger." Additionally, panelist 2 indicated the use of a food journal to increase awareness.

Addressing external and behavioral concerns. This theme incorporates several treatment recommendations regarding social and behavioral concerns, stress, and physical appearance. In regard to social concerns, panelist 1 identified, "all (my emotional eating clients) live in an environment that is highly food-centric, loaded with harmful choices, and usually surrounded by peers who sabotage, knowingly or otherwise."

When asked about stress management, four panelists stated that they did not address stress directly. For example, panelist 1 stated, "this gets addressed with everyone, but as part of the general goal of creating greater quality of life such that food urges become easier to manage." Four panelists reported that they did address stress directly. In this respect, panelist two identified, "Yes. Useful, especially if a client feels overwhelmed and uses food to get calm and zone out."

In regard to behavioral concerns, panelist 2 discussed isolating behavior stating that emotional eating manifested for her clients via, "eating more than planned, fantasizing about a food until they must have it; feeling ashamed if/when over-eat; sometimes out of awareness or consciousness, they tune out while eating; (eating) when alone; (and) sneaking food."

Three panelists also discussed addressing negative views regarding body image. Panelist 7 elucidated, "we had to get in touch with her body, from which she often hid or dismissed." Two of these panelists used artistic expression in order to address body image. For example, panelist 5 identified that he used, "creativity, cartooning to get in touch with body image issues."

Addressing co-existing conditions. In QI panelists were asked to list client co-existing conditions, seven panelists stated their clients experienced anxiety and six stated their clients experienced depression (See table 4). Therefore recommendation was generated regarding co-existing conditions. An additional recommendation was generated regarding the use of medication as medication has been helpful in ameliorating both anxiety and depression (Arnold et al., 2002).

Theme III: Therapeutic Foundations Group Therapy

Six therapists identified that they treated clients in a group therapy setting, therefore a theme and corresponding questions regarding group therapy were generated (see Table 3). As there is little academic research regarding group therapy specifically for emotional eating, no recommendations were generated for QI to assess group therapy. Therefore, the researcher used general recommendations for emotional eating found in both the review of literature and feedback from QI.

Theme VI: Recommended Resources for Emotional Eaters

Four panelists cited utilizing additional resources in QI to help aid their clients with emotional eating. Two panelists mentioned working with a nutritionist. Two panelists also indicated working with a general practitioner. For example, panelist 9 stated that, “I treat underlying emotional issues in long term therapy and refer to nutritionist and md for food and medical management.” Additionally, panelist 8 mentioned the importance of social support. A further review of literature indicated that support groups are another way individuals can increase social support for emotional eating (Reel, 2013).

Summary: Questionnaire I

Many of the recommended treatments found in the literature review and listed in QI were identified as being utilized in the therapeutic process. These recommendations were therefore, included in Q2. Only one was not continued explicitly in Q2, identifying self-criticism and replacing it with positive self-talk. While panelists agreed that identifying self-criticism and replacing it with positive self-talk could be useful, five panelists challenged the idea of positive self-talk. Two panelists felt that self-talk had to match beliefs and that is was difficult to change negativity bias in this way. Additionally, panelist 3 stated, "replacing it with positive self-talk is only a temporary fix. I work to understand the reason for the negative self-talk." Therefore, this was shortened to a more general statement concerning self-criticism found in the sub-theme of addressing the therapeutic process and obstacles.

Results Questionnaire II

Discussing Emotional Eating

Two recommendations regarding discussing emotional eating with clients qualified (median score of 4.0 or greater and an IQR of 1or less) for final consideration for treatment recommendations (see Table 4). Panelists rated therapist calling attention to emotional eating as very important, a median of 4-4.99. Panelists rated that therapists be aware of the potential impact of their own physicality on both the therapeutic alliance and possible counter transference as essential, a median of 5. In this regard, panelist 5 noted in this theme's comment section," I lost 20 pounds recently after a surgery and many of my clients who are overweight commented."

The following three recommendations were not retained for final consideration as they did not meet the median requirement of 4 or higher or did not meet a high enough consensus of 1 IQR or less: (1) Therapists should let clients bring up emotional eating. (2) Therapists should go

slowly when discussing emotional eating. (3) To reduce shame, therapists should normalize the prevalence of emotional eating behavior.

Table 4
Discussing the Therapeutic Process

	Median	IQR
Therapist should let clients bring up emotional eating.	4.00	1.5
Therapists should call attention to client's emotional eating behavior .	4.00	0.0
Therapists should go slowly when discussing emotional eating with clients.	4.00	1.5
To reduce shame, therapists should normalize the prevalence of emotional eating behavior.	4.00	1.5
Therapists should be aware of the potential impact of their own physicality (overweight, underweight, normal weight) on the therapeutic alliance and/or counter transference.	5.00	0.5

Addressing the Therapeutic Process and Obstacles

Panelists rated (IQR of 1 or less) seven elements of addressing the therapeutic process and obstacles as either very important or essential (See Table 5). Panelists rated that therapists should explain the therapeutic process and specifically that the process may be non-linear as essential, a median score of 5. In addition, panelists rated essential that therapists provide psychoeducation about maladaptive eating behavior as well as address ambivalent feelings regarding change. Panelists rated that the therapists address low self-esteem and self-efficacy and identify and address negative attitudes or beliefs as very important, a median of 4-4.99.

The statement, that in order to reduce feelings of shame, therapists should normalize that changing behavior can be difficult, was not retained for final consideration as it did not meet a high enough consensus of an IQR of one or less.

Table 5
Addressing the Therapeutic Process & Obstacles

	Median	IQR
Therapists should discuss the therapeutic process (in terms of treatment for emotional eating).	5.00	1.0
Therapists should explain that the therapeutic process may be non-linear to reduce discouragement.	5.00	0.5
Therapists should provide psychoeducation about maladaptive eating behavior.	5.00	0.5
Therapists should address ambivalent feelings clients may have about changing their relationship with food.	5.00	1.0
Therapists should help clients identify and address self-defeating behaviors.	5.00	0.5
Therapist should address low self-esteem and self-efficacy.	4.00	0.0
Therapists should help clients identify and address negative attitudes and beliefs.	4.5	1.0
To reduce feelings of shame, therapists should normalize that changing behavior can be difficult.	5.0	2.0

Addressing Emotional Eating as Affect Regulation

Results showed that panelists rated essential (median of 5) with a high level of consensus (IQR of 1 or less) that therapists help clients understand emotional eating as affect regulation and that this is essential to treatment. Panelists also rated essential that therapists help clients become more aware of negative emotions as well as to address and process them. Panelists rated identifying prevailing negative emotions as very important, a median of 4.0 or higher. (See Table 6).

In regard to addressing negative affect panelist 2 commented that:

> I help the client identify when he/she is feeling angry or annoyed (or any variation of that) or disgusted or any feeling that is unpleasant to tolerate. However, dealing with

anger, etc. and what you refer to as 'negative' emotions is often an essential part of dealing with emotional eating, especially for women, who often find it difficult to express anger (or even accept anger) in a healthy assertive .

Panelist 1 felt differently stating that, "It's more often about reducing unnecessary exposure to triggers than it is about trying to work through every passing feeling, which can feel endless for some people."

Table 6
Addressing Emotional Eating as Affect Regulation

	Median	IQR
Therapists should help the client emotional eating in terms of affect regulation (therapists may or may not use the phrase affect regulation when explaining).	5.00	0.5
Therapists should identify prevailing negative affect or emotions.	4.00	1.0
Therapists should help clients become more aware of the impact of negative emotions on eating.	5.00	0.5
Therapists should work with clients to address and process negative emotion.	5.00	1.0

Identifying Alternative Coping Mechanisms

Panelists rated identifying alternative coping mechanisms and that these coping mechanisms are realistic and workable as essential, median of 5 and IQR of l or less. Panelists also felt that helping clients come up with a plan or strategy for events where food or individuals might be a trigger is also essential. In addition, encouraging clients to develop their own support system as a form of coping was rated as very important, median of 4 - 4.99 (see Table 7).

Regarding current coping techniques, panelists 2 commented, "focus on current coping techniques are essential - BUT not necessarily more so than dealing with past pain and trauma --

IF that is what usually drives the individual to eat emotionally. They are both important for some clients."

The recommendation that therapists focus more on current coping techniques rather than past pain and trauma, was not retained for final consideration because it did not meet the median requirement of 4 or higher or did not meet a high enough consensus of 1 or less.

Table 7
Identifying Alternative Coping Mechanisms

	Median	IQR
Therapists should help clients identify alternative coping mechanisms to emotional eating.	5.00	1.0
Therapists should work with clients to come up with realistic and workable coping alternatives.	5.00	1.0
Therapists should focus more on current coping techniques rather than past pain and trauma.	3.50	3.5
Therapists should encourage clients to develop their own personal support system.	4.00	1.0
Therapists should help clients come up with a plan or strategy for events where food or individuals might be a trigger.	5.00	0.5

Increasing Emotional Awareness

Panelists rated helping clients better understand their emotional relationship with food as essential, a median of five or higher. Panelists also rated essential that therapists address underlying feelings of guilt and shame. Panelists rated helping clients understand the emotional cycle and teaching emotional language as very important, a median of 4-4.99. See Table 8.

Panelist 9 further discussed feelings of shame stating that "oftentimes chronic dieters have shame around weight cycling and this is very important to address particularly around restrictive diets."

The following recommendations were not retained for final consideration as they did not meet the median requirement of 4 or higher or did not meet a high enough consensus: (1) Therapists should help clients get in touch with their emotions. (2) Therapists should encourage clients to identify where emotions occur in their body. (3) Therapists should encourage clients to journal in order to increase emotional awareness. In regard to the importance of increasing emotional awareness panelist 1 commented: "With the exception of guilt and shame which can destroy all therapeutic efforts, it's not nearly as important to increase emotional literacy as it is to increase awareness of triggers and to be effectively strategic in response."

Table 8
Increasing Emotional Awareness

	Median	IQR
Therapists should help clients get in touch with their emotions.	4.00	2.0
Therapists should help clients better understand their emotional relationship with food.	5.00	0.5
Therapists should help client understand their emotional cycle.	4.00	1.0
Therapists should teach clients emotional language in order to increase emotional awareness.	4.00	1.0
Therapists should encourage clients to identify where emotions occur in their body.	3.50	2.0
Therapists should encourage clients to journal in order to increase emotional awareness.	3.00	0.5
Therapists should help clients identify and address underlying feelings of guilt and shame.	5.00	1.0

Understanding Personal Narratives and History Regarding Food

Panelists rated that understanding history and personal narrative regarding food and exploring family and cultural background as both very important, median range of 4-4.99 with a

high degree of consensus, an IQR of 1 or less (see Table 9). In terms of exploring culture, panelist 6 stated, "We coach on how culture accepts binge eating and fear and even anxiety - drama. To be clear, calm and strategic and eating for fuel not fun/reward/social glue/ etc. might mean being considered strange!"

The recommendation of encouraging clients to use a journal in order to help clients better understand personal narratives, was not retained for final consideration as it did not meet the median requirement of 4 or higher or did not meet a high enough consensus of 1 or less. Panelist 1 further commented on this recommendation that, "Food journaling is crazy-making for some people, and a useful tool for others. Client(s) must carefully self-assess to see whether it is beneficial for them or not."

Table 9
Understanding Personal Narratives and History Regarding Food

	Median	IQR
Therapists should help clients better understand their history and personal narrative regarding food.	4.00	0.0
Therapists should encourage clients to keep a food journal in order to help them better understand their narrative and relationship with food.	3.00	1.0
Therapists should explore the client's family and cultural background with food in order to help the client better understand patterns and triggers.	4.0	0.5

Addressing Attachment Injuries and Past Trauma

Therapists agreed, IQR of 1 or less, that it is very important, median of 4-4.99, to explore the relationship between eating behavior and unmet emotional and relational needs. Panelists also rated as very important that therapists should address past trauma and post-traumatic stress disorder (PTSD) in order to better understand how this might relate to emotional eating. See Table 10. Panelist 3 further stated, "These must be addressed IF they are causing the need for

maladaptive coping skills. With exploration it will become clear if the client needs to go in that direction."

Table 10
Addressing Attachment Injuries and Past Trauma

	Median	IQR
Therapists should explore the relationship between eating behavior and unmet emotional and relationship needs.	4.00	1.0
Therapists should address PTSD, trauma, and hurt in order to help clients better understand their role in client's emotional eating behavior.	4.00	1.0

Addressing Ruminative and Repetitive Thinking About Food

Panelists rated identifying ruminative and repetitive thinking about food as essential, median of 5 and an IQR of 1 or less (see Table 11). Panelist 3 further noted that:

> This symptom usually comes up very early on in therapy and can be addressed as needed. It is a sign that the person is obsessed with food for any number of reasons. Interrupting the repetitive thinking will not help the underlying cause of the thoughts. That is the ultimate goal.

The recommendation that clients should be instructed to interrupt ruminative and repetitive thinking and then engage in an ameliorating activity such as walking or journaling was not retained for final consideration. It did not meet a high enough consensus an IQR of 1 or less.

Table 11
Addressing Ruminative and Repetitive Thinking About Food.

	Median	IQR
Therapists should help clients identify ruminative and repetitive thinking about food	5.00	1.0
Clients should be instructed to interrupt ruminative and repetitive thinking and then engage in an ameliorating activity such as walking or	4.00	1.5

journaling.

Increasing Mindfulness

Panelists rated increasing mindfulness as essential, a median of 5, with a high degree of consensus, IQR 1 or less. Panelists rated as very important, median of 4 -4.99, the utilization mediation and mindful eating in order to increase mindfulness. They also agreed and rated as very important to for therapists to understand that not all clients may be interested in these techniques and that therapist should help find alternatives to both mediation and mindful eating. Panelist 2 further commented that, “there are no 'shoulds' here. IF the client is amenable to meditation, intuitive eating, a food-log/journal, then fine. If not, then we need to help the client find alternatives.” Panelist one agreed “Mindfulness is essential for truly getting on top of food issues, but there's no one-size-fits-all approach to achieving that. Some people just can't get there.”

The recommendation of keeping a food log or journal in order to increase mindfulness was not included in the final recommendations for treatment. It did not meet the median requirement of 4 or higher or did not meet a high enough consensus of 1 or less. See table 12. Regarding journaling, panelist 8 commented, “Food journals can be helpful for most clients but they can also contribute to over focus and rumination so again it depends.”

Table 12
Increasing Mindfulness

	Median	IQR
Therapists should teach clients about mindfulness.	5.00	0.5
Therapists should help clients increase mindfulness through meditation.	4.00	1.0
Therapists should help clients increase mindfulness through mindful eating.	4.00	1.0

Meditation can be helpful in increasing mindfulness but not all clients may be interested. The therapist should help the client find alternatives to meditation.	4.00	0.5
Mindful eating can be helpful to increase mindfulness but not all clients are interested. The therapist should help clients find alternatives to mindful eating.	4.00	0.5
Therapists should encourage clients to keep a food log or journal to be more aware of food consumption.	3.00	1.0

Addressing Physical, Social, and Environmental Concerns

Panelists rated essential that therapists help clients manage unsupportive home or social environments, median of 5 and IQR 1 or less (See table 13). Panelists also identified as being very important (median range of 4-4.99) helping clients identify trigger foods, people, and situations as well as identify isolating and secretive behavior in regard to eating and food, and addressing negative view of body image.

The following three recommendations were not retained for final consideration as they did not meet the median requirement of 4 or higher or did have a high enough consensus of 1 IQR or less: (1) involving family and close friend in therapy in therapy, (2) using artistic expression to get in touch with body, (3) unless the client brings it up, therapists should not directly address stress management. Regarding the recommendations of involving family and friends in therapy panelist 2 stated, “the client's family MIGHT be helpful, or might not,” panelist 1 agreed, “Sometimes it's helpful to talk to family and friends, but sometimes they aren't healthy inputs and are best kept out of the process.” Panelist 1 also commented on addressing stress stating, “better stress management will be a free side-benefit of doing the things that create more control with food, but can be added to if necessary.”

Table 13
Addressing Physical, Social, and Environmental Concerns

	Median	IQR
Therapists should help clients identify trigger foods, / situations, and people.	4.00	1.0
Therapists should help clients identify isolating or secretive behavior in regards to eating and food.	4.00	1.0
Therapists should help clients manage unsupportive home or social environments (E.g. if family or friends encourage eating habits and foods the client is trying to avoid, despite knowing the client is working to change emotional eating).	5.00	1.0
Therapists should encourage the client to talk to family and friends about ways in which to be supportive.	4.00	1.0
The therapists should encourage clients to include family or close friends to participate in therapy.	3.00	1.0
Unless the client brings it up, therapists should not directly address stress management (this is resolved through the therapeutic process without being addressed directly.	3.00	2.0
Therapists should work with clients to address negative view of body image.	4.00	0.5
One way therapists should encourage clients to get in touch with their body via artistic expression (E.g. tracing the client's body or having them color or draw a picture of their body and identify emotions).	3.00	1.5

Addressing Co-Existing Conditions

Panelists rated addressing co-existing conditions in order to treat emotional eating is essential, median of 5 with a high degree of consensus, IQR of 1 or less (See Table 14).

The recommendation that co-existing conditions be treated with medication and therapists should encourage clients to seek psychiatric support to gain access to medication did not reach a high enough consensus of an IQR of 1 or less. Regarding medication, Panelist 3

stated that, “medications blunt symptoms and also create new eating symptoms. I believe medication should be responsibly avoided as much as possible. It makes doing the work so much harder.”

Table 14
Addressing Co-existing Conditions

	Median	IQR
In order to treat emotional eating therapists must also address co-existing conditions.	5.00	0.5
For co-existing conditions that can be treated with medication, therapists should encourage clients to seek psychiatric support to gain access to medication.	4.00	2.0

Theme III: Therapeutic Foundations Group Therapy

There were 13 general recommendations generated regarding group therapy. Increasing emotional awareness was the only treatment recommendation rated as essential, a median of 5, with high consensus, IQR of 1 or less. Nine recommendations were rated as very important, a median range of 4-4.99 (see table 14). Three recommendations did not meet the requirement for consensus. This include, therapists providing structure and topics, normalizing the prevalence of emotional eating to reduce shame, and interrupting ruminative and repetitive thinking. Panelist 1, the only panelist to comment, stated that “it's more about management of triggers than it is about deep emotional work, though there will be some overlap.”

Table 15
Therapeutic Foundations: Group Therapy

	Median	IQR
Therapists should structure groups and provide topics.	4.00	1.5
Provide psychoeducation about food and eating.	4.00	0.5

Normalize prevalence of emotional eating behavior to reduce shame.	4.00	1.5
Help clients identify trigger foods, situations, and people.	4.00	1.0
Encourage clients to develop their own personal support system.	4.00	1.0
Help clients understand emotional eating in terms of affect regulation (therapist does not have to use the phrase affect regulation).	4.00	1.0
Help clients identify alternative coping mechanisms to emotional eating.	4.00	1.0
Help clients increase emotional awareness.	5.00	1.0
Help clients understand family and cultural background regarding food in order to help better understand patterns and triggers.	4.00	1.0
Address attachment injuries.	4.00	1.0
Help clients identify and address feelings of guilt and shame.	4.00	1.0
Help clients identify and interrupt ruminative and repetitive thinking about food.	4.00	1.5
Help clients increase mindfulness.	4.00	1.0

Recommended Resources for Emotional Eaters

Panelists did not agree with high consensus, IQR one or less, regarding recommendations encouraging clients to seek external resources. Panelist additionally rated encouraging clients to address emotional eating with their primary care physician and working with a nutritionist lower than a median of four. Therefore, none of the recommendations regarding recommended resources for emotional eaters were retained for the final recommendations.

In regard to this theme, panelists had many comments. Panelist 1 stated that these all depend on client's individual needs. Panelist two stated that books and videos are excellent resources, but did not specify which ones. Panelist one notes that, "physicians are generally poorly informed about eating-related issues, especially emotional eating. Nutritionists can be

helpful - but often people know a lot about nutrition (but not always).” Two panelists, one and two also cautioned about support groups panelist one stated:

> “Support groups are not a "gimme" in terms of support. Some of them are quite unhealthy and can do more harm than good, which is the case for any kind of support group. Groups need to be personally vetted, or recommended with the caution that quality varies and the client needs to be alert to whether the group has an empowering influence or not.”

Panelist two stated “the client may not want a group, or may have difficulty with the 12 steps, or a higher power, or whatever.”

Table 16
Recommended Resources for Emotional Eaters

	Median	IQR
In addition to therapy, therapists should encourage and make recommendations for clients to seek additional resources.	2.00	1.5
Clients should be encouraged to address emotional eating with their primary care physician.	3.00	0.5
Therapists should encourage clients to work with a nutritionist.	3.00	1.0
Clients should be encouraged to seek support groups such as "overeaters anonymous" to gain acceptance and understanding.	3.00	1.0

Recommendations for Treatment Length and Group Size

In addition to rating treatment recommendations, panelists were also asked to identify the average length of treatment for their emotional eating clients as well as the recommended group size and number of sessions for group therapy. On average, panelists identified that treatment for emotional eating typically lasted an average of 3.14 months. Recommended group size was six to eight persons and number of group sessions was an average of 5.71.

Summary: Questionnaire II

Ultimately, from the 70 questions generated for QII, 47 recommendations (58.44%) met the criteria for inclusion. These recommendations are listed below (see Table 16).

The 22 recommendations that did not meet the criteria all fell within a median of 3.00-3.99, which indicates "unknown or not sure" within this study's Likert rating system. As these recommendations did not meet the criteria (Median=4 or less and IQR=1 or more), they were not included in the final recommendations for treatment.

In addition to analyzing the data quantitatively multiple coders we utilized in order to further organize qualifying recommendations into treatment themes. Ultimately, the following nine themes were generated: (1) initial therapeutic engagement, (2) psychoeducation, (3) identifying patterns, (4) working with emotions and feelings, (5) coping, (6) psychosocial, (7) increasing awareness, (8) group therapy and, (9) other.

Table 17

Qualifying Treatment Recommendations

Initial Therapeutic Engagement	Median	IQR
Therapists should call attention to client's emotional eating behavior.	4.00	0.0
Therapists should be aware of the potential impact of their own physicality (overweight, underweight, normal weight) on the therapeutic alliance and/or counter transference.	5.00	0.5
Therapists should discuss the therapeutic process (in terms of treatment for emotional eating).	5.00	1.0
Therapists should explain that the therapeutic process may be non-linear to reduce discouragement.	5.00	0.5
Therapists should address ambivalent feelings clients may have about changing their relationship with food.	5.00	0.5
Psychoeducation	Median	IQR
Therapists should provide psychoeducation about maladaptive eating behavior.	5.00	1.0

Therapists should help the clients understand emotional eating in terms of affect regulation (therapists may or may not use the phrase affect regulation when explaining).	5.00	0.5
Working with Emotions and Feelings	Median	IQR
Therapists should identify prevailing negative affect or emotions.	4.00	1.0
Therapists should help clients become more aware of the impact of negative emotions on eating.	5.00	0.5
Therapists should work with clients to address and process negative emotion.	5.00	1.0
Therapists should help clients better understand their emotional relationship with food.	5.00	0.5
Therapists should help client understand their emotional cycle.	4.00	1.0
Therapists should teach clients emotional language in order to increase emotional awareness.	4.00	1.0
Therapists should help clients identify and address underlying feelings of guilt and shame.	5.00	1.0
Therapist should address low-self-esteem and self-efficacy	4.00	0.0
Coping	Median	IQR
Therapists should help clients identify alternative coping mechanisms to emotional eating.	5.00	1.0
Therapists should work with clients to come up with realistic and workable coping alternatives.	5.00	1.0
Therapists should encourage clients to develop their own personal support system.	4.00	1.0
Therapists should help clients come up with a plan or strategy for events where food or individuals might be a trigger.	5.00	1.0
Identifying Patterns	Median	IQR
Therapists should help clients identify ruminative and repetitive thinking about food.	5.00	1.0
Therapists should help clients identify trigger foods, situations, and people.	4.00	1.0

Therapists should help clients identify and address self-defeating behaviors.	5.00	0.5
Therapists should help clients identify isolating or secretive behavior in regards to eating and food.	4.00	1.0
Increasing Awareness	Median	IQR
Therapists should teach clients about mindfulness.	5.00	0.5
Therapists should help clients increase mindfulness through meditation.	4.00	1.0
Therapists should help clients increase mindfulness through mindful eating.	4.00	1.0
Meditation can be helpful in increasing mindfulness but not all clients may be interested. The therapist should help the client find alternatives to meditation.	4.00	0.5
Mindful eating can be helpful to increase mindfulness but not all clients are interested. The therapist should help clients find alternatives.to mindful eating.	4.00	0.5
Psychosocial	Median	IQR
Therapists should help clients better understand their history and personal narrative regarding food.	4.00	0.0
Therapists should explore the client's family and cultural background with food in order to help the client better understand patterns and triggers.	4.00	0.5
Therapists should help clients manage unsupportive home or social environments (E.g. if family or friends encourage eating habits and foods the client is trying to avoid, despite knowing the client is working to change emotional eating).	5.00	1.0
Therapists should explore the relationship between eating behavior and unmet emotional and relationship needs.	4.00	1.0
Therapists should encourage the client to talk to family and friends about ways in which to be supportive.	4.00	1.0
Therapists should work with clients to address negative view of body image.	4.00	0.5
Other	Median	IQR

In order to treat emotional eating therapists must also address co-existing conditions.	5.00	0.5
Therapists should work with clients to address negative view of body image.	4.00	0.5
Therapists should address PTSD, trauma, and hurt in order / to help clients better understand their role in client's emotional / eating behavior.	4.00	1.0

Therapeutic Foundations of Group Therapy	Median	IQR
Provide psychoeducation about food and eating.	4.00	0.5
Help clients identify trigger foods, situations, and people.	4.00	1.0
Encourage clients to develop their own personal support system.	4.00	1.0
Help clients understand emotional eating in terms of affect regulation (therapist does not have to use the phrase affect regulation).	4.00	1.0
Help clients identify alternative coping mechanisms to emotional eating.	4.00	1.0
Help clients increase emotional awareness.	5.00	1.0
Help clients understand family and cultural background regarding food in order to help better understand patterns and triggers.	4.00	1.0
Address attachment injuries.	4.00	1.0
Help clients identify and address feelings of guilt and shame.	4.00	1.0
Help clients increase mindfulness.	4.00	1.0

V. Discussion

The purpose of this study was to elicit smart practice treatment recommendations from a panel of experts regarding emotional eating and propose final recommendations for treatment of emotional eating clients in a therapeutic setting. Ultimately, 47 recommendations met the criteria for inclusion (see Table 17). In addition, while panelists indicated using a variety of different models to treat client's with emotional eating, final recommendations remained general rather than specific to a certain model or theoretical stance.

These final recommendations were reorganized into nine treatment themes. In order to further elucidate the results of this study, these finding will first be compared with results found in the review of literature. A more in-depth discussion highlighting both recommendations and implications for treatment will then be followed by study limitations and suggestions for future research.

Correspondence of Results with the Relevant Literature

There were several themes within the literature that were consistent with panelists' comments in the study. Firstly, all panelist agreed that emotional eating was a form of affect regulation, further supporting the findings in academic literature (Ball & Lee, 2002; Denisoff & Endler, 2000; Freeman & Gil, 2004; Koff & Sangani, 1997; Oliver, Wardle, & Gibson, 2000; Van Strien & Ouwens, 2003). Emotions identified in the literature such as anxiety, loneliness, self-judgment, boredom and shame (Bennett et al, 2012; Heatherton & Polivy, 1992, Hernandez-Hons &Woolley, 2012; Reel,2013) were also reported by panelists, see Table 3. Additionally, a pattern of ruminative and repetitive thinking about food prior to emotional eating, identified in a 2011 study, (Kemp et al.) was also acknowledged by panelists as occurring in their clients. This study also found that, at least in terms of those that seek therapeutic intervention, emotional

eating occurs more often in women than in men (Agras & Telch, 1998; Polivy et al., 1994; Tabor, 2006; Ganely, 1989; Macht, 1999; Macht & Simons, 2000; Van Strien & Ouwens, 2003). Panelists also identified that a majority of their clients experienced depression and anxiety (see Table 3), consistent with literature that found that individuals who engage in emotional eating have a higher prevalence of both anxiety and depression (Konttinen., et al,2010; Pidgeon, et al., 2012).

Panelist agreed with six treatment recommendations found in the review of literature. These include: (1) identifying alternative coping options, (2) increasing emotional awareness, (3) understanding personal narratives and history regarding food, (4) addressing attachment injuries and, (5) increasing mindfulness through techniques such as meditation and mindful eating, (6) and addressing stress.

This study asked panelists about the importance identifying alternative coping mechanisms for emotional eating and panelists agreed that these are either essential or very important. This corresponds with recommendations made by Andrews et al. (2011) who identified that increasing coping options and strategies could assist emotional eaters in incorporating more adaptive strategies.

Increasing emotional awareness was identified by several researchers as a way to increase access to more adaptive coping mechanisms (Foy, 2000; Kemp, Bui, & Grier, 2011; Kidwell, Hardesty, & Childers, 2008). Panelists also acknowledged that increasing emotional awareness was recommended for group therapy as well.

Increasing understanding of personal narratives was identified in the literature as a component of treatment used to help clients better understand their own schema in terms of family and cultural relationships with food. The supposition is that by identifying these

narratives, clients could comprehend and then renegotiate their relationship with food as a form of coping (Bekker et al., 2004; LeBel et al., 2008). In this study, panelists agreed and rated this recommendation as very important. Some panelist felt it was useful in providing context while others indicated it is essential for the client to increase understanding of personal narratives in order for "healing" to occur.

Addressing attachment injuries is a recommendation that has been found to help target maladaptive affect regulation (Hernandez-Hons & Woolley, 2011; Mikilincer et al., 2003). Panelists agreed and rated that it is very important to address attachment injuries in terms of exploring the relationship between emotional eating and unmet emotional and relationship needs.

Mindfulness, the most researched treatment recommendation for emotional eating, has been found to help moderate emotional eating behavior and increase self-compassion (Pidgeon et al., 2012). In this study panelists agreed that increasing mindfulness is an essential recommendation for treatment. In addition, techniques to increase mindfulness and mediation found in the literature were also endorsed by panelists. However, panelists identified that not all clients will be interested in utilizing these techniques and that therapist should help clients find alternatives to increasing mindfulness.

Recommendations and Implications for Treatment

These recommendations are made with the caveat that each client will have unique needs and therefore the recommendations should be applied based on the needs of the individual client. In addition, excluding initial engagement, these recommendations are not arranged in a particular order and may overlap during the therapeutic process.

Initial therapeutic engagement. Panelists identified that clients may come into therapy specifically to address emotional eating and therefore may address the topic themselves.

However, not all clients may do so. In particular, this may occur if the therapist does not advertise treatment specifically for emotional eating. Therefore, it is recommended that if emotional eating is causing the client distress, the therapist inquire about the client's emotional eating behavior. This should be done carefully and with emphasis on the therapist explaining the nature therapeutic process with specific regards to emotional eating. For example, it may be important in order to help reduce discouragement, that therapists discuss the possibility of the therapeutic process being non-linear. It is also recommended that therapists discuss possible client ambivalence about changing emotional eating behavior. For example, clients may want to stop emotional eating behavior but may also find it difficult to give up food as a coping mechanism. Therapists should also be aware of the impact of their own physicality regarding counter transference and the therapeutic alliance.

Psychoeducation. In order to help clients better understand the prevalence and nature of emotional eating therapists might provide psychoeducation regarding emotional eating. This could include explaining the nature of eating as affect regulation, though the therapist may or may not use that specific phrase.

Working with emotions and feelings. When working with emotions therapists might help clients better understand their emotional relationship with food. In particular therapists could help clients become aware of the impact of negative emotions on eating behavior. In this regard therapists could help clients address and process these negative emotions. In order to achieve this, therapists might teach clients emotional language.

As emotional eating clients may experience feelings of guilt and shame as well as low-self-esteem and self-efficacy, therapists could help clients address and process these feelings.

These feelings in particular, may be related to failed dieting attempts of the clients weight around weight.

Psychosocial. If problematic, therapists could help clients manage unsupportive home and social environments. For example, family and friends may encourage eating habits and food that the client is trying to change or avoid. In addition therapists might help clients better understanding their history and personal narrative regarding eating and food. This may include encouraging the client to talk with family and friend about ways in which they can be more supportive. Additionally, exploring the family and cultural background might help clients further understand patterns and triggers around food and eating.

Clients may have a negative view regarding their body which could be related to social norms and expectations, in which case, therapists could help clients address these views so they can be better in touch with their body.

Coping. Therapists are encouraged to help clients increase their coping options by helping them find alternative coping methods that are both realistic and workable. This might include encouraging them to develop their own personal support system, and helping them to strategizing about events where food or particular individuals might be a trigger. In addition, therapists might address client stress especially if clients appear overwhelmed and are eating in response to stress.

Increasing mindfulness. Panelists identified that it's important that therapists help clients increase mindfulness. This might involve the utilization of mindfulness based practices such as meditation or mindful eating. However, therapists should keep in mind that while these methods are effective, not all clients will be interested in utilizing them. Therefore, therapists

might be prepared to help clients come up with alternative techniques that focus on increasing mindfulness.

Identifying patterns. It is recommended that therapists be aware that clients may engage in ruminative or repetitive thinking around food and help clients identify when this is occurring and then help them find ways in which to interrupt it. Therapists might also help clients become more aware of their behavior around eating such as isolating or being secretive. Finally, therapists might work with clients to identify foods, situations, and people that may be a trigger for them to engage in emotional eating.

Other. It is recommended when working with emotional eating clients to address co-existing conditions and their possible impact on emotional eating behavior. In addition, some emotional eating clients may be eating in response to past trauma and current PTSD. If this is the case, therapists might help clients better understand the role that these events play in their emotional eating behavior.

Group therapy. Therapists who conduct group therapy for emotional eating could plan to have six to eight individuals in their group and conduct five to six session of group therapy. In a group setting it is recommended that therapists help clients increase emotional awareness. In addition, group therapy might also include a pychoeducational component regarding emotional eating as well as an explanation of emotional eating in terms of affect regulation. Therapists could work to help clients identify and address feelings of guilt and shame. Therapists might also help clients understand family and cultural backgrounds as well as address attachment injuries and identify trigger foods, people, and situation. Other components or group therapy might involve focusing on increasing mindfulness and helping clients identify alternative coping mechanisms.

Implications for Future Research

There are few studies in academic literature that have generated treatment recommendations specifically for emotional eating. This study aimed to provide a preliminary exploration of general treatment recommendations for emotional eating. The 45 elements identified by the nine expert panelists are an attempt to provide a basic foundation for treatment exploration. Therefore, future research could be applied in several key areas. For example, future studies could further examination the initial interaction between therapists and clients, specifically the impact of the therapist's physicality on the therapeutic relationship. In addition, a study could identify a relevant and applicable curriculum of pychoeducational information for emotional eaters. Future studies might also explore recommendations for alternatives to mindfulness based techniques as well as ways in which to increase positive social support. Another salient area of research could further explore therapeutic elements of group therapy to specifically address emotional eating.

Finally, the panelist's responses to the questionnaires do not represent a larger sample of individuals who are experts in the field of treatment for emotional eating. More extensive research regarding all 45 recommendations utilizing a larger sample of participants would be beneficial in order to gain broader insight and validity regarding treatment recommendations.

Limitations of This Study

This study contains several limitations. Firstly, there are limitations within the very nature of the Delphi method. This method relies on the knowledge, integrity, and expertise of the panelists to obtain validity and the very nature of this process can be prone to both oversight and bias (Dawson & Brucker, 2001). Additionally, the panelist in this study do not represent all individuals whose expertise involves emotional eating, therefore the scope of this study is limited

to the nine panelists represented. However, as mentioned earlier, the results of this study are not meant to be absolute and should not be used independently of current research and literature.

This study was also limited by a smaller sample of expert panelists due to the specificity regarding panelist requirements. However, the study did provide a diverse sample of both experiential and theoretical backgrounds. Additionally, the researcher did not ask panelists their ethnic and racial background. In hindsight, this information may be useful to ensure greater panelist diversity.

Another limitation occurred during the first questionnaire. The researcher failed to specify that panelists should provide generalities for both demographics and treatment recommendations. Ultimately, two panelists provided information regarding a specific client. While this information was relevant regarding case application, it is limited in terms of general treatment practice. The researcher asked panelist to provide information in general terms for QII.

Additionally, this study did not include a third questionnaire in order to further validate final recommendations for treatment. For example, panelists were not able to rate or comment on the treatment recommendations generated from the first two questionnaires. Ultimately, the third round was eliminated due to time constraints and to reduce panelist fatigue.

Conclusion

This Delphi study explored identified and proposed treatment recommendations for emotional eating based on the opinions of expert panelists. These experts identified 47 recommendations. Many of these recommendations agreed with those found in relevant literature. However, this study revealed several themes of treatment that have not been identified with specific regard and correspondence to treatment for emotional eating. These include initial

therapeutic engagement, basic recommendations for group therapy, the use of psychoeducation, and addressing the influence of past trauma.

The hope is that this study will inform therapeutic practice, future research, and increase academic knowledge regarding smart treatment practices for emotional eating.

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Appendix A

Email Letter I

Dear_____,

I am a master's student in the Human Development program at Virginia Tech and am currently conducting a Delphi study to evaluate best treatment practices for clients who struggle with emotional eating yet do not meet the DSM-5 diagnostic criteria for an eating disorder, such as Binge Eating Disorder or Bulimia Nervosa. I would like to invite you to participate as an expert panelist in my study. As an expert in the field providing treatment for emotional eating, your participation will be greatly appreciated. Through your assistance, this research will help identify key concepts and processes for creating better guidelines for treatment.

To qualify as an expert panelist in this study, you must meet the following criteria:

1) Have treated an adult who engaged in emotional eating, **yet do not meet the DSM-5 critera for an eating disorder ,** during the past three years.
2) Be a licensed clinician, holding a qualifying degree (LMFT, LPC, LCSW, PhD or PsyD, etc)
3) Must meet one criteria from the following list:
    a. Have at least two years clinical experience treating adults who engage in emotional eating yet do not meet the critera for an eating disorder
    b. Conducted a peer reviewed study on the topic of emotional eating
    c. Given lectures or trainings on the topic of emotional eating

If you meet the above criteria and are interested in serving on the expert panel please read through the following steps:

1. After reading through the below step: Click on this survey link:
2. *Enter the following identification number:
3. Read the participation information form at the beginning of the questionnaire. Reading this form and continuing with the questionnaire will imply consent.
4. Complete the first questionnaire. Thus should take approximately 20-30 minutes.
5. Once all data has been collected and reviewed a second questionnaire will be generated. You will be sent a second e-mail with a link to the second questionnaire as well as your unique identification number. The second questionnaire should take approximately 15-20 minutes.
6. When all data has been collected and reviewed from the second questionnaire you will be sent the final results of this study.

*In order to keep your data confidential each panelist will have their own unique identification

number.

Kindly complete the first questionnaire by _____.

Your involvement in the study is completely voluntary and you may withdraw from the study at any time without consequences. There is minimal risk to participate in the study. You may experience some fatigue completing the surveys. Further information regarding participation including risks and benefits can be found at the beginning of the first questionnaire.

I look forward to working with you in the next few weeks. If you have any questions about this study please do not hesitate to contact me.

Sincerely,
Meagan Bailey
meagan79@vt.edu

Appendix B

Informed Consent

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Participation Information
For Research Projects Involving Human Subjects

Title of Project: Recommended Therapeutic Interventions for Emotional Eating: A Delphi Study

Principle Investigator: Angela Huebner

I. Purpose of Research

The purpose of this study is to investigate and evaluate best treatment practices for clients who engage in emotional eating yet do not meet the criteria for an eating disorder. We are interested in learning about what you have found and believe to be the most effective treatment methods.

II. Procedures

You will be asked to complete a demographic survey and two questionnaires. You will not put your name on either the survey or the questionnaires in order to keep them confidential. After you complete the first questionnaire, you will be asked to complete a second questionnaire. The length of time it takes to complete the questionnaire will depend on how much detail you choose to provide. Your participation in this study is completely voluntary. If you wish to discontinue your participation in this study at any time, you may do so without facing any adverse consequences.

III. Risks

Risks of participating in this study are minimal. As a result of participating in this study, you may become fatigued and not wish to continue.

IV. Benefits

As a participant in the study, you will receive a description of the findings.

V. Extent of Anonymity and Confidentiality

Strict confidentiality of information will be preserved. You will be assigned an identification number that will be kept separate from any identifying information, and your questionnaires will contain only this identification number. Your name will not be associated with the answers you provide in the questionnaire. Names will not be used on any reports or publications that are developed from the results of this study. All results will be presented as aggregates of all responses.

VI. Compensation

There is no compensation for participating in this survey.

VII. Freedom to Withdraw

You do not have to participate in this research study. If you agree to participate, you can withdraw your participation at any time without penalty.

VIII. Participant's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibility:

1. I will complete two questionnaires to the best of my ability.

IX. Participant's Permission

I have read the information sheet about the conditions of this study. I understand that continuing on and completing the questionnaires gives my consent to allow my answers to be used in the research.

If you have any questions about this research study or its conduct, and research subjects' rights, and whom to contact in the event of a research-related injury to the subject, I may contact:

Meagan B. Bailey	703-963-0010/meagan79@vt.edu
Investigator	Telephone/e-mail
Angela Huebner, Ph.D.	703-538-8491 /ahuebner@vt.edu
Investigator	Telephone/e-mail
David M. Moore	540-231-4991/moored@vt.edu
Chair, Virginia Tech Institutional Review Board for the Protection of Human Subjects Office of Research Compliance	Telephone/e-mail

Appendix C

Questionnaire I

1. Please describe key characteristics and elements of working with this population; please include the following if applicable:

    A. How the topic of emotional eating was introduced?
    B. Client's willingness to address emotional eating in a therapeutic setting.
    C. What emotions did your client most identify with emotional eating?
    D. How does emotional eating manifest for them?

2. Do you view emotional eating as a form of affect regulation? How does your perspective impact how you treat clients?

4. Recommendations and guidelines for therapeutic intervention please include:

    A. Models and techniques used, please provide detailed information regarding application of techniques and rationale for use of model
    B. Obstacles and Challenges
    C. Desirable outcome

5. The following twelve elements have been suggested as possible treatment options for emotional eating based on a review of literature. However, how the effectiveness and utilization of these recommendations are largely unknown in research literature. In order to better understand their impact on positive therapeutic outcomes please provide your thoughts on the elements below. Please discuss their usefulness/effectiveness, how you use them and how often they use them, if you do not utilize them please discuss this decision.

Treatment Components

1. Identifying alternative coping mechanisms

2. Identifying self-criticism and replacing it with positive self-talk
3. Increasing understanding of personal narratives in relation to food by examining the role food plays within in family and cultural background
4. Increasing understanding of personal narratives in relation to food by examining the role food plays within in family and cultural background
5. Increasing understanding of internal emotional processes
6. Exploring and identifying behavioral patterns and cures relating to emotional eating i.e. patterns of dieting/ food restriction and overindulging in food, Times of day when emotional eating occurs, Trigger foods, and social events
7. Addressing attachment injuries
8. Mindfulness
9. Meditation
10. Mindful Eating
11. Addressing feelings of guilt and shame
12. Stress Management
13. Identifying and interrupting ruminative and repetitive thinking about food

Appendix D

E-mail Letter II

Dear _____,

Thank you very much for participating as an expert in study evaluating treatment for emotional eating!

From the feedback provided by you and other expert practitioners, a second questionnaire has been generated. This second questionnaire will ask you to answer four general demographic questions and then numerically rate (from 1-5) components of treatment identified in the first questionnaire.

To start the second questionnaire: Click here

***Enter your ID number _____**

(This survey should take approximately 10-15 minutes to complete.)

Kindly complete this survey by _____

*By entering your ID number this will allow me to group responses from both questionnaires together appropriately for data analysis and keep your answers anonymous.

There is minimal risk to participate in the study. Your involvement in the study is completely voluntary and you may withdraw from the study at any time without facing adverse consequences.

Participants will receive a final copy of the results once they have been analyzed.

Thank you very much for your time and participation,

Meagan Bailey

M.S. MFT Candidate, Virginia Tech

Appendix E

Questionnaire II

Demographics II:

Average recommended length of treatment

3 months 6 months one year over 18 months +

Average recommended size of group for group therapy:_____

Average recommended number of session for group therapy

4 6 8 10 12 more than 12

(Approximate) Average age of clients' _____

QII

Please rate the following recommendations for treatment of emotional eating

Likert rating scale of 1–5

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

(At the end of each category you will be given the option to add commentary or questions, however, commentary or questions are part of the requirement complete the questionnaire.)

<u>Please rate elements based on a generalization of best treatment practices for emotional eating clients only</u>

Discussing emotional eating and the therapeutic process with clients

Discussing Emotional Eating
1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should let clients bring up emotional eating.
2. Therapists should call attention to client's emotional eating behavior.
3. Therapists should go slowly when discussing emotional eating with clients.
4. To reduce shame, therapists should normalize prevalence of emotional eating behavior.

5. Therapists should be aware of the potential impact of their own physicality (overweight, underweight, normal weight) on the therapeutic alliance and/or counter transference

Addressing the therapeutic process and obstacles

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should discuss the therapeutic process (in terms of treatment for emotional eating).
2. Therapists should explain that the therapeutic process may be non-linear to reduce future discouragement.
3. Therapists should provide psychoeducation about maladaptive eating behavior.
4. Therapists should address ambivalent feelings clients may have about changing their relationship with food.
5. Therapists should help clients identify and address self-defeating behaviors.
6. Addressing low self-esteem and efficacy (make it a sentence).
7. Therapists should help clients identify and address negative attitude and beliefs.
8. To reduce feelings of shame, therapists should normalize that changing behavior can be difficult.

Therapeutic Foundations: Individual Therapy

Addressing Emotional Eating as Affect Regulation

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should help the client understand cycle of emotional eating in terms of affect regulation (therapists may or may not use the phrase affect regulation when explaining).
2. Therapists should identify prevailing negative affect or emotions.
3. Therapists should help clients become more aware of the impact of negative emotions on eating.
4. Therapists should work with client to address and process negative emotions.

Identifying alternative coping mechanisms

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should help clients identify alternative coping mechanisms to emotional eating.
2. Therapists should work with clients to come up with realistic and workable coping alternatives.
3. Therapists should focus more on current coping techniques rather than past pain and trauma.
4. Therapists should encourage clients to develop their own personal support system.

5. Therapists should help clients come up with a plan or strategy for events where food or individuals might be a trigger.

Increasing Emotional Awareness

Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should help clients get in touch with their emotions.
2. Therapists should help clients better understand their emotional relationship with food.
3. Therapists should help client understand their emotional cycle.
4. Therapists should teach client emotional language in order to increase emotional awareness.
5. Therapists should encourage clients to identify where emotions occur in their body.
6. Therapists should encourage clients to journal in order to increase emotional awareness.
7. Therapists should help clients identify and address underlying feelings of guilt and shame.

Understanding personal; Narratives and history regarding food

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should help clients better understand their history and personal narrative regarding food.
2. Therapists should encourage clients to keep a food journal in order to help them better understand their narrative and relationship with food.
3. Therapists should discuss the client's family and cultural background with food in order to help the client better understand patterns and triggers.

Addressing Attachment Injuries and Past Trauma

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should explore relationship between eating behavior and unmet emotional and relationship needs.
2. Therapists should address PTSD, trauma, and hurt in order to help clients better understand their role in client's emotional eating behavior.

Identifying and interrupting ruminative and repetitive thinking about food

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should help clients identify ruminative and repetitive thinking about food.
2. Clients should be instructed to interrupt ruminative and repetitive thinking and then engage in an ameliorating activity such as walking or journaling.

Mindfulness

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should teach clients about mindfulness.
2. Therapists should help clients increase mindfulness through meditation.
3. Therapists should help increase mindfulness through mindful eating.
4. Meditation can be helpful in increasing mindfulness but not all clients may be interested. The therapist should help the client find alternatives to meditation.
5. Mindful eating can be helpful to increase mindfulness but not all clients are interested. The therapist should help clients find alternatives to mindful eating.
6. Therapists should encourage clients to keep a food log/journal to be more aware of food consumption.

Addressing physical, social, and environmental concerns

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. Therapists should help clients identify trigger foods, situations, and people.
2. Therapist should help clients identify isolating or secretive behavior in regards to eating and food.
3. Therapists should help clients manage unsupportive home or social environments (E.g. if family or friends encourage eating habits and foods the client is trying to avoid, despite knowing the client is working to change emotional eating).
4. Therapists should encourage the client to talk to family and friends about ways in which to be supportive.
5. The therapists should encourage the clients to include family or close friends to participate in therapy.
6. Unless the client bring it up, therapists should not directly address stress management (this is resolved through the therapeutic process without being addressed directly.
7. Therapists should work with clients to address negative view of body image.
8. One way therapists should encourage clients to get in touch with their body via artistic expression (E.g. tracing the clients body or having them color or draw a picture of their body and identify emotions).

Addressing Co-existing conditions

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. In order to treat emotional eating therapists must also address co-existing conditions.
2. For co-existing condition that can be treated with medication, therapists should encourage clients to seek psychiatric support to gain access to medication.

Therapeutic Foundations of Group Therapy

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. When seeing clients in a group setting therapists should:
    a. Structure groups and provide topics.

b. Provide psychoeducation about food and eating.
c. Normalize prevalence of emotional eating behavior to reduce shame.
d. Help clients identify trigger foods, situations, and people.
e. Encourage clients to develop their own personal support system.
f. Help the client understand cycle of emotional eating in terms of affect regulation (therapist does not have to use the phrase affect regulation).
g. Help clients identify alternative coping mechanisms to emotional eating.
h. Help clients increase emotional awareness.
i. Help clients understand family and cultural background regarding food in order to help better understand patterns and triggers.
j. Address attachment injuries.
k. Help clients identify and address feelings of guilt and shame.
l. Help clients identify and interrupt ruminative and repetitive thinking about food.
m. Help clients increase mindfulness.
n. List any other:

Recommending Resources for Emotional Eaters

1. Essential 2. Important 3. Do not know/not sure 4. Unimportant 5. Should not be included

1. In addition to therapy, therapists should encourage and make recommendations for clients to seek additional resources.
2. Clients should be encouraged to address emotional eating with their primary care physician.
3. Therapists should encourage clients to work with a nutritionist.
4. Clients should be encouraged to seek support groups such as overeater anonymous to gain acceptance and understanding.
5. List any other:

Appendix F

IRB Approval Letter

VirginiaTech

Office of Research Compliance
Institutational Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website http://www.irb.vt.edu

MEMORANDUM

DATE: February 25, 2014

TO: Angela J Huebner, Meagan Bailey

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)

PROTOCOL TITLE: Recommended Therapeutic Interventions for Emotional Eating: A Delphi Study

IRB NUMBER: 14-214

Effective February 25, 2014, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 7**
Protocol Approval Date:	**February 25, 2014**
Protocol Expiration Date:	**February 24, 2015**
Continuing Review Due Date*:	**February 10, 2015**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Appendix G

IRB Approval Letter Amendment

VirginiaTech

Office of Research Compliance
Institutational Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website http://www.irb.vt.edu

MEMORANDUM

DATE: April 1, 2014

TO: Angela J Huebner, Meagan Bailey

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)

PROTOCOL TITLE: Recommended Therapeutic Interventions for Emotional Eating: A Delphi Study

IRB NUMBER: 14-214

Effective March 31, 2014, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the Amendment request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 7**
Protocol Approval Date:	**February 25, 2014**
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The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.