Exploring emotional eating and its management among Middle Eastern females living in the UK: From exploration to culturally adapted intervention

Exploring Emotional Eating and its Management Among Middle Eastern Females Living in the UK: From Exploration to Culturally Adapted Intervention.

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Declaration

I declare that this thesis is the outcome of my work; I have adequately referenced and cited the initial resource when using other individuals' research or ideas.

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Abstract

Rationale: Emotional Eating (EE) is a worldwide concern due to its potential impact on physical health. Despite this, there is a dearth of research and interventions, particularly among the Middle Eastern population whereby cultural differences are overlooked. This research was undertaken in two phases using a mixed-methods approach.

Phase 1 Method: Semi-structured interviews explored EE among sixteen Middle Eastern females who identified EE as something they would like to better manage (mean age = 37, SD = 4.13).

Results: Thematic analysis identified three themes compromising of: '*Experiences of Emotional Eating'*, '*Factors Perceived as Influencing Emotional Eating*' and '*Recommendations for culturally adapted Emotional Eating interventions'*. These findings, along with relevant literature, and use of patient and public involvement and engagement (PPIE) were utilised when developing a culturally adapted intervention for delivery in phase two.

Phase 2 Method: Thirteen Middle Eastern women participated in four sessions of Cognitive Behavioural group therapy over four weeks. This involved psychoeducation, identifying and challenging thoughts, goal setting, problem-solving, and formulating relapse plans. Ten participants were in a waiting list control group for comparative purposes.

Results: Participants completed the emotional eating subscale from the modified Dutch Eating Behaviour Questionnaire (DEBQ: Bailly et al., 2012). A repeated ANOVA analysed pre- and post-scores to assess the effectiveness of the intervention, and a statistically significant ($F1, 21= 49.18$, $p<.001$ $\eta^2=.701$) reduction in participants' EE post-intervention was found. Thematic analysis revealed the benefits of sharing and hearing others' stories and psychoeducation in increasing understanding of EE and improving coping strategies for the management of unmet needs and unpleasant emotions.

Implications: Findings offer insight into Middle Eastern women's experiences of EE, factors which contribute towards it, and the outcomes of a culturally adapted intervention intended to help manage EE. Future research could explore the use of culturally adapted interventions longitudinally to examine individuals' experiences with, and management of EE longer term.

Dedication

I would like to dedicate my thesis to my beloved friend Zarqa

"I am a better person by knowing you, loving you, and meeting you. May you be as fortunate in your next life as I was in something by knowing you, my friend".

(Rest in peace)

I would also like to express my deepest gratitude to my beloved son Yousif, you are the reason for starting my journey of studying psychology. You have taught me to believe in myself. I love you deeply, and may you rest in peace.

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List of abbreviations and acronyms

Emotional Eating	EE
Cognitive behavioural therapy	CBT
Mental Health	MH
Middle Eastern and Northern Africa	MENA
Black, Asian and Minority Ethnicity	BAME
Black and Minority Ethnicity	BME
Mixed Method	MM

List of Definitions

Middle Eastern refers to the nation-state of North Africa, the Arabian Peninsula, Iraq and the Levant. The Middle Eastern and North Africa (MENA) region encompasses the following 27 states; Yemen, Iraq, Tunisia, United Arab Emirates (UAE), Jordan, Iran, Kuwait, Lebanon, Egypt, Libya, Qatar, Morocco, Saudi Arabia, Oman, Algeria, Bahrain, Israel, Malta, and Palestine. The following countries are sometimes considered part of MENA: Armenia, Azerbaijan, Djibouti, Mauritania, Somalia, Western Sahara, Turkey and Sudan (Istizada, 2022). The majority of the Middle Eastern countries speak Arabic, excluding Iran, for which the spoken language is Persian or Farsi, while Israel speaks Hebrew, and Turkey speaks Turkish (Scardilla, 2017).

Arab refers to individuals from North Africa or Western Asia who speak Arabic (Cambridge dictionary, 2022).

Mood refers to affective states which are diffuse and instinctive, that is, not focused on a specific object. This means that they are continually present (stimuli) and thus shape contextual of individuals' moment-moment experiences but swing over time. Time pattern and directedness are two vital features that differentiate moods from emotions (Lischetzke, 2014).

Emotions refer to affective conditions directed at a specific object (being happy about achievement) and are phasic, meaning that they have a starting point and then dispel (Lischetzke, 2014).

Emotional Eating (EE) refers to (over) eating in response to unpleasant and pleasant emotions, including depression, irritability, stress, or anxiety (Frayn, Livshits & Knauper, 2018; Strein, 2018; VanStrien, 2013), with food consumption is used to regulate emotions.

Emotion regulation (ER) refers to individuals attempting to influence emotions, defined as situational bound, time-limited and valence (negative or positive) states. This means that ER is restricted to the downregulation of negative emotions; however, it incorporates up and down-regulation of negative and positive emotions in harmony with regulation-correlated goals. ER can be an explicit and thus conscious process it can also occur implicitly and therefore outside their awareness (McRae & Rose, 2020).

Contents

CHAPTER ONE: Introduction and Context of the Research

1.1 Background

Emotional Eating (EE) is defined as (over) eating in response to unpleasant and pleasant emotions, including depression, irritability, stress, anxiety, happiness, joy, or excitement (Frayn et al., 2018; Van Strein, 2018; Van Strien, 2013), with food consumption, used to regulate emotions (Robinson et al., 2015). For example, food consumption may provide a distraction from unpleasant feelings such as anxiety or relief from boredom (Herle et al., 2018). Also, food may also be used to connect with others, form part of celebrations, or provide a reward or treat, thereby associating with pleasant emotions (Micanti et al., 2016; Robinson et al., 2015; Van Strein, 2018). Research has evidenced EE in Saudi Arabia as well as other Middle Eastern countries such as United Arab Emirates, Jorden, and Sudan, with the growing burden of weight gain via EE partially attributed to cultural changes influenced by westernisation, including an increased availability of fast food (Al-Musharaf, 2020; Fatima & Ahmed, 2018).

EE links to heightened consumption of high-fat or sugary foods, consistently associated with health issues like obesity and other health related issues (Fray et al., 2018; Micanti et al., 2016; Konttinen, 2020; Robinson et al., 2015; Strein, 2018). Obesity, characterised by excessive fat accumulation, is measured by body mass index (BMI). A BMI of 30+ is obese, 25-29.9 is overweight, and 18.5-24.9 is average weight (World Health Organisation, 2019). Globally, obesity prevention is paramount, with 1.9 billion adults overweight and 650 million obese (Kent et al., 2017). The UK's Health Survey (2020/2021) unveiled a rise in obesity, affecting 25.3% of adults, up from 24.4% (2019-2020) and 22.7% (2015-2016). In terms of gender prevalence, Male and female obesity rates are concerning between ages 45-74, with 68% of men and 60% of women being obese or overweight (NHS,

2020). Similarly, obesity plagues Middle Eastern populations (MEP), having the world's second-highest overweight and obesity rates after Northern America (Al-Rodhan et al., 2019; Nikoloski & Williams, 2016).

A Recent pooled estimate indicates a 21.17%-33.14% obesity and overweight prevalence in MEP, rising with age, especially in those aged >40 (Okati-Aliabad et al., 2022). Lifestyle changes, including sedentary habits such as physical inactivity, unhealthy eating habits, and social, cultural, and economic changes contribute to higher BMIs (Okati-Aliabad et al., 2022). A recent systemic review (of 87 studies) exploring the indirect effect of obesity-related risk during the first year of the pandemic showed increased food and alcohol intake, sedentary behaviour, financial stress and depression during the pandemic, driving post-pandemic obesity spikes in Western and Middle Eastern populations (Daniels et al., 2022).

Obesity escalates risks like cardiovascular, diabetes, cancer, kidney diseases, and musculoskeletal disorders (Kyrou et al., 2018), curtailing life expectancy and quality while upping hospital expenses, including NHS costs (Kent et al., 2017; The King's Fund, 2021). In the UK ethnic minorities, compared to white counterparts, report poorer health and higher disease incidence, mortality, and prevalence (The King's Fund, 2021). Similarly, minority groups exhibit poorer mental health as well, including heightened maternal depression among South Asian women (Khan et al., 2019) and elevated self-harm rates (2009-2016) compared to white groups (Husain et al., 2006; Farooq et al., 2021; Husain et al., 2011

According to the latest UK's population ethnic composition, per the 2019 Census UK, includes a 7.5% Asian segment, with an estimated 0.4% being Arabs (230,600 individuals). For Middle Eastern populations in the UK, obesity risk elevates for diseases like diabetes, cancer, and heart conditions (Okati-Aliabad et al., 2022; Yousif, 2008). Notably, obesity rates (2019) vary among ethnic groups: Black (31%), other (including Arabs) (27.6%), and White British (26.4%). Given EE's potential to exacerbate obesity and health woes. Therefore, since

EE can lead to obesity and other health-related diseases, it is vital to address the knowledge gap of EE among Middle Eastern populations living in the UK.

Exploring cultural differences is crucial for comprehending EE among Middle Eastern women residing in the UK (Reddy & Van Dam, 2020). This encompasses factors like emotion-triggering situations, emotional expression, help-seeking behaviour, nutritional awareness, social context, and the cultural connection with food (Al-Nohair, 2014). Food choices and eating habits serve as tangible symbols of ethnic identity preservation, especially when the individual's culture is in the minority within their surroundings (Reddy & Van Dam, 2020).

Research examining food consumption and EE among various cultures reveals similarities and differences between these cultures (Prescott et al., 2002). However, limited information is available regarding Middle Eastern populations. Mental health foundation (MHF) highlights that Middle Eastern populations, among B.A.M.E. groups, face higher mental health risks due to societal challenges like discrimination and inequalities (MHF, 2019). To add, acculturation, may give rise to heightened stress or conflict as two cultures vie for prominence (Nguyen & Peterson, 1993). Acculturation is the exchange and adoption of cultural elements when different cultures interact. It involves mutual influence, adaptation, and can influence cultural identity. The outcomes of acculturation vary from enrichment to potential conflicts, for example being linked to a decrease in family support (Gil et al., 2000). Such outcomes have been evidenced among Arabic communities within the UK (Abu Rayya & Brown., 2022; Alawfi, 2019). Moreover, a body of research underscores the impact of acculturation on mental health, providing further insights into the complex relationship between acculturation and psychological well-being (e.g., Berry, 2006; Schwartz et al., 2010). These investigations collectively suggest that greater acculturation can be associated

with adverse mental health outcomes. As such, this might make unpleasant emotions more prevalent, leading to increased emotional eating vulnerability.

Whilst prevention, treatment, and diagnosis services for EE may be considered advanced within westernised countries, help-seeking among Middle Eastern individuals in Europe, the UK, and USA is challenging, attributed to gender norms, modesty, misconceptions, and cultural beliefs (Al-Bkerat, 2019). For Middle Eastern populations, considerations such as gender preference, modesty concerns, misconception, and disease causation ideas informed by cultural beliefs and practices all influence health-seeking behaviours (Al-Bkerat, 2019). For example, perception, beliefs, and practices may influence incidences of obesity as thinness is seen as a reflection of poor health and malnutrition among Middle Eastern populations (Al-Bkerat, 2019). Further, Emotion suppression and inhibition within this cultural context may hinder sharing emotions and seeking psychological treatment (Nehme, 2018). This further shape help-seeking behaviour and therapeutic engagement, thus inhibiting or influencing the psychological treatment.

In conclusion, EE and its association with psycho-physiological health concerns among Middle Eastern populations in the UK, particularly those linked to obesity, presents important implications for counselling psychology. EE is a complex phenomenon, and counsellors must recognise and explore cultural nuances shaping emotional responses and eating behaviours within this population (Frayn et al., 2018; Van Strein, 2018). Increasing rates of obesity and associated health risks in Middle Eastern populations emphasises the importance of developing culturally sensitive interventions (Okati-Aliabad et al., 2022; Kyrou et al., 2018; The King's Fund, 2021). Counselling strategies should consider the cultural significance of food choices, emotional triggers, and the impact of acculturation on mental health (Berry, 2006; Nguyen & Peterson, 1993; Reddy & Van Dam, 2020).

The disparity as compared to westernised population in health outcomes and mental health risks among ethnic minorities, including Middle Eastern populations, as reported by The King's Fund (2021) and MHF (2019), requires a tailored approach in counselling psychology. Acknowledging the challenges related to help-seeking behaviours within these communities, influenced by gender norms and cultural beliefs (Al-Bkerat, 2019; Nehme, 2018), is crucial for effective therapeutic engagement. Research exploring food consumption patterns and emotional eating across different cultures (Prescott et al., 2002) emphasises the need for targeted interventions that consider cultural contexts. In addressing this knowledge gap regarding EE in Middle Eastern populations living in the UK, counselling psychologists have a pivotal role to play.

1.2 Research Aims and Objectives

The objectives of the initial phase of this research were to comprehensively comprehend the EE encounters of non-clinical Middle Eastern women residing in the UK. Alongside public engagement endeavours, these findings would shape the creation of a culturally sensitive pilot intervention aimed at aiding EE management within this demographic. The objectives of the subsequent phase of this study were centred on piloting the EE intervention. This intervention concentrated on enhancing participants' awareness of emotional eating, pinpointing triggers for emotional eating, and imparting strategies to manage triggers and regulate emotions through methods other than food.

1.3 Rationale for Examining Emotional Eating among Middle Eastern Females

Emotional eating, a behaviour where individuals consume food in response to emotions rather than hunger, is a complex phenomenon with multifaceted implications. Assessing EE among Middle Eastern women is of value for several interconnected reasons. First, Middle Eastern cultures have a strong emphasis on communal gatherings where food serves as a

central element. This cultural backdrop underscores the importance of understanding how cultural practices shape eating behaviours and emotional responses, providing insights into the nuances of emotional eating within this context (Frayn et al., 2018). Furthermore, previous research has indicated that females, in general, may be more susceptible to uncontrolled emotional eating, particularly when stressed (Davis et al., 2012; Due et al., 2022; Zellner et al., 2006). Second, the pervasive influence of traditional gender roles and societal expectations in many Middle Eastern societies significantly impacts women's experiences, including their relationship with food and emotions. The intersection of being female and moving to a westernized country may further compound these challenges, placing Middle Eastern women at a heightened risk of developing mental health disorders (Stratrion et al., 2019). Factors such as increased childcare burden, and heightened risk of experiencing violence, common among migrant women, can contribute to this vulnerability (Social Determination of migrants, 2016). Thus, exploring EE within this framework offers critical insights into the broader impact of societal constructs on women's eating behaviours and emotional well-being (Lim, 2016; Zolezzi et al., 2018).

Third, emotional eating is closely intertwined with mental health concerns, including stress, anxiety, and depression. Given the stigmatisation of mental health in certain Middle Eastern communities, understanding the dynamics of emotional eating becomes pivotal in fostering broader conversations around mental health awareness, support, and intervention strategies (Reddy & Van Dam, 2020). Furthermore, cultural influences on social norms and expectations by gender can significantly shape emotional experiences and coping mechanisms, further emphasising the need for a nuanced understanding of EE among Middle Eastern women (Davis et al., 2012).

Working as a counselling psychologist trainee with Middle Eastern women, it became apparent that the undertaking and dissemination of research with this population could support the efforts of practitioners in developing their cultural understandings of EE. This in turn would help counselling practitioners identify and use of culturally adapted interventions used to manage EE. Therefore, phase one of this research programme sought to address this gap by gaining an in-depth understanding of the EE experiences of Middle Eastern women living in the UK**.** The aims of this study were to explore Middle Eastern women's:

- perceptions and experiences of emotional eating,
- cultural influences on these experiences, and
- Perceptions of existing EE interventions, along with recommendations for interventions tailored to their needs.

1.4 Research Approach

An ethnographic approach guided this research program, as it provides a profound understanding of individuals' perspectives, meanings, and actions by contextualising their culture through interviews (Berkwits & Inui, 1998; Reeves, Kuper & Hodges, 2008). This approach aligns with the constructivism-interpretivism framework, aligning with the authors' epistemological views (Suzuki et al., 2014). Ethnography delves into narratives grounded in various contexts, such as historical, social, or economic ones. Suzuki et al. (2015) argue that integrating contextual information is crucial for comprehending diverse cultural groups; the absence of such a framework for interpreting data stems from researchers' uninformed perceptions.

Ethnographic techniques were employed to amass comprehensive data and insights into participants' experiences of EE and their perceived needs for its management. All participants self-identified as needing better EE management, a criterion for inclusion in this

research program. Ethnographic techniques encompassed participant observation and data collection through interviews (Suzuki et al., 2014). While ethnography is often conflated with participant observation, Trimmer and Wood (2016) propose that the methodology is more expansive due to its range of methods and its overall orientation in research. Suzuki et al. (2014) suggest that observation involves becoming part of the community, achieved through methods like observing individuals or groups, using unstructured interviews, leveraging researchers' field notes, and documentary analysis.

These principles have been integrated into this research project in various ways. Firstly, the researcher is part of the Middle Eastern community due to their Middle Eastern heritage. Secondly, the researcher has been providing support to Middle Eastern women since 2012, initially in a voluntary capacity and later during doctoral training by offering one-on-one and group therapy, leading to an enhanced comprehension of Middle Eastern culture. Thirdly, the researcher spent six weeks in Iraq during the summer of 2022, gaining insight and experience of contemporary Middle Eastern culture (see Appendix H for the researcher's observation notes from this experience).

Prior studies have effectively employed ethnographic methods to explore food choices, perceptions of healthy eating, and understanding emotional experiences, including health-related research on complex interventions (Fox et al., 2021; Hedican, 2006; Trimmer & Wood, 2016). For example, ethnographic techniques such as free listing have been used by previous nutrition studies to investigate perceptions about foods (Hough & Ferrais, 2010; Kalra et al., 2018), habits and meal patterns (de Morais Sato et al., 2019; Libertino et al., 2019), and nutrition information (Fox et al., 2018). Employing ethnographic techniques benefits the identification of underlying perceptions and generates valid data that can enhance the design and content of health promotion interventions to better reflect the targeted population's perspectives (Fox et al., 2021; Trimmer & Wood, 2016).

1.4 Research Questions

This programme of research was undertaken in two phases; phase one utilised semi-structured interviews to explore EE among Middle Eastern females living in England. Findings from phase one, along with implications drawn from the literature review were shared when involving and engaging Middle Eastern women in helping to develop a culturally adapted brief intervention intended to help manage emotional eating. Moving on to the second phase, a mixed-methods approach was employed. This phase encompassed the evaluation of the culturally adapted intervention's effectiveness through quantitative methods and its acceptability through qualitative methods. The schematic representation of the research program's design can be found in Figure 1. Below, the research questions and/or hypotheses for each respective phase are presented.

Phase 1 (qualitative exploratory):

Research question 1: What are the experiences of EE among Middle Eastern females residing in the UK?

Research question 2: What are their perceptions of existing EE interventions (including the extent to which they address cultural needs)?

Research findings suggest that engaging with the target population prior to intervention implementation is of paramount importance. This is primarily due to the inherent variations in individuals' experiences, expressions, and regulation of emotions, which are shaped by cultural values and norms. The formulation of two distinct research questions aimed to provide invaluable insights that could subsequently guide the development of a culturally adapted intervention focused on the management of emotional eating.

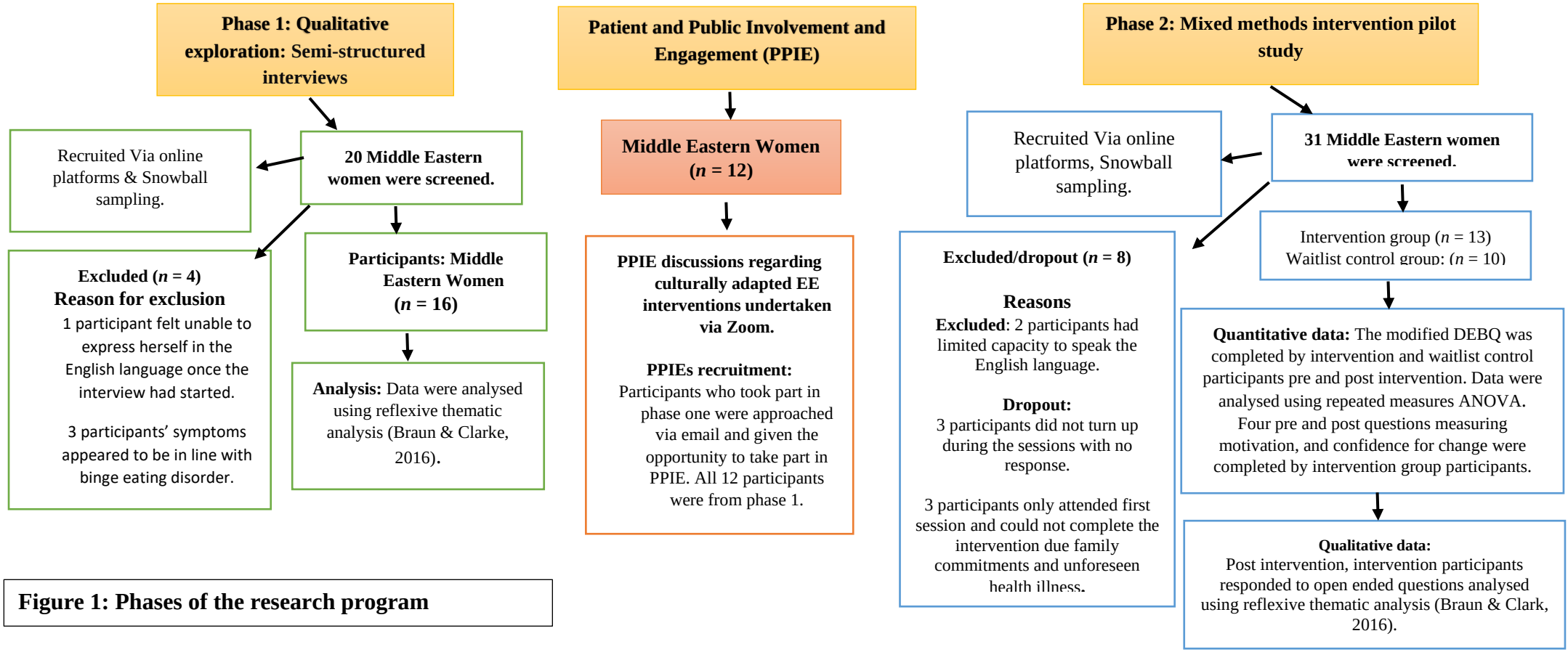

Figure 1: Phases of the research program

1.5 Thesis Structure

The current research project comprises of eight chapters (see Figure 2) in which the aims and objects of this programme of research are addressed.

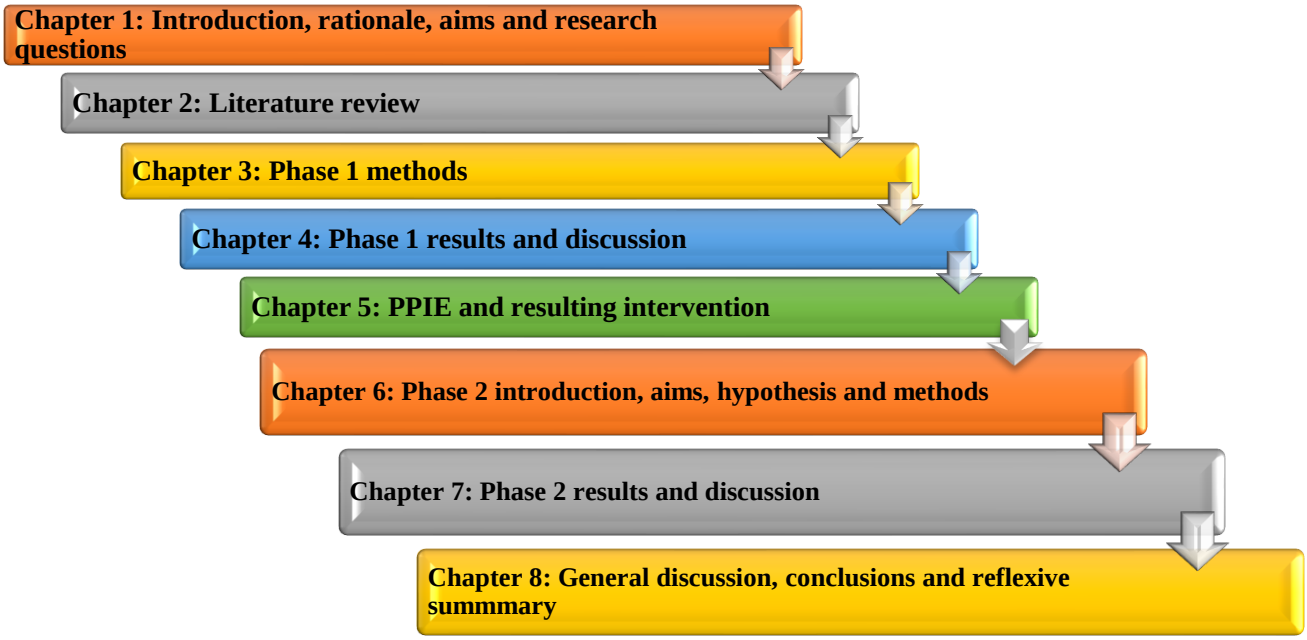

Figure 2. Flow chart presenting the structure of the doctoral thesis.

Chapter one outlines the research rationale, aims, and research questions. **Chapter two** describes and critiques underpinning EE theories and literature comprehensively. **Chapter three** introduces the phase one methodology: semi-structured interviews with Middle Eastern women. These interviews explored EE perceptions, emotional experiences, and knowledge of existing EE interventions and intervention needs. **Chapter four** presents reflexive thematic analysis findings, emphasising insights into Middle Eastern women's EE and emotion management. Phase one reveals in-depth insight into Middle East women's understanding of EE and factors influencing the management of emotions and EE, such as living away from their family, being immersed in a new culture, and lifestyle changes. **Chapter five** presents the process and outcomes of patient and public involvement (PPIE) intended to explore and address intervention needs in seeking to better manage EE. This included considerations such

as intervention content, venue, time, delivery method (e.g., online/face-to-face, and one-to-one or in a group) and support for continuation (e.g., self-guided book or continue with the group). Insights from phase one and PPIE informed the development of the intervention.

Chapter six provides a brief introduction, aims and method of phase two in which the EE intervention was delivered and evaluated. The intervention comprised of four group sessions (each lasting three hours) where the participants were provided with CBT once a week to help manage their emotional eating. **Chapter seven** presents a quantitative and qualitative evaluation of the pilot test of a culturally adapted EE intervention. In this chapter, the strengths and limitations of the intervention, as well as future research directions are discussed. **Chapter eight** concludes the thesis, discussing key findings and their clinical implications. This chapter also presents a personal reflection on personal growth as a researcher/practitioner and the application of the research to clinical practice.

CHAPTER TWO: Literature Review

2.1 Defining Emotional Eating

Emotional eating (EE) is commonly described as consuming excessive food in response to negative emotions like anger, sadness, or stress, rather than true physical hunger (Limbers & Summers, 2021; van Strien, 1996). Additionally, overeating and high calorie intake are associated with positive emotions such as happiness and relaxation (Devonport et al., 2019; Evers et al., 2018). Food's connection with positive emotions is evident in its role for social bonding, celebrations, and rewards (Athena, 2015; Micanti et al., 2016; Strein, 2018). For example, a meta-analysis laboratory studies indicate that induced positive moods are linked to overeating, regardless of individuals' health or eating disorder status (Cardi et al., 2015).

EE is often considered maladaptive due to its association with food cravings and consumption of high-calorie, sugary, and fatty foods, leading to unwanted weight gain (Devonport et al., 2022; Kelly, 2013; Shen et al., 2020). The literature review sections encompass: 1) emotions and food consumption, 2) influences on EE, 3) importance of Understanding cultural, 4) EE management interventions and cultural adaptation needs, and 5) summary.

2.2 Emotions and Food Consumption

Emotions influence food choices, and conversely, food can impact the response and expression of both negative and positive emotions. Research primarily focuses on emotions such as stress, anxiety, and depression, showing a potential link to increased food consumption (Konttinen et al., 2010; Konttinen et al., 2019; Oliver et al., 2000; Van Strien et al., 2012). However, other emotions, including sadness, anger, boredom, irritability, loneliness, happiness, confidence, relief, love, pleasure, and excitement, can also trigger EE

(Cancian et al., 2019; Fuente González et al., 2022; Manchon et al., 2021; Robinson et al., 2015). Whilst there is more evidence for unpleasant emotions leading to EE, research has associated positive emotions to overeating and binge eating (Bongers et al., 2016), due to an enhanced drive to eat highly palatable and sugary food (Cardi et al., 2015). This demonstrates that eating serves not only as a coping mechanism but also as a way to enhance positive emotions (Manchón et al., 2021).

Considering evidence for emotions influencing EE, Hill et al.'s (2018) meta-analysis indicates that stress can lead to increased consumption of low-nutrition, high-calorie foods such as takeaways and snacks between meals. Similarly, in research on the impact of negative and positive emotions on eating behaviour among clinical and non-clinical samples, Zhou et al. (2021) discovered that positive emotions heightened hedonistic eating behaviour in participants.

The findings also revealed participants increased food intake to sustain their experience of pleasure. They concluded that emotions and food consumption are undeniably linked and advised considering factors like symbolism, social culture, and individual eating habits, which influence the connection between emotions and eating behaviour. The correlation between unpleasant and pleasant emotions and EE has been observed in various groups, including healthy individuals, weight-related categories, and those with eating disorders, in both experimental (Cardi et al., 2015) and psychometric research (Nicholls et al., 2016). In reviewing the evidence pertaining to emotional eating, unpleasant emotions will be examined first, followed by pleasant emotions.

Research indicates that individuals turn to food to manage the impact of unpleasant emotions such anxiety and stress (Herle et al., 2018). For instance, boredom, often considered a negative emotion, has been linked to increased appetite in various studies (Crockett et al., 2015; Koball et al., 2012; Schnepper et al., 2020).

Certain life events, such as relocating to a new country, can also trigger unpleasant emotions such stress and sadness (Terragine et al., 2022; Xia et al., 2022). Perhaps intuitively, a great deal of research has focused on the obese population to explain EE (Nguyen-Rodriguez et al., (2009). For example, Sims et al. (2008) found that perceived stress contributed significantly to EE in obese and overweight individuals compared to the broader sample.

Thayer (2001) proposes that heightened feelings of low energy and tension often lead to EE as a response to underlying negative emotions like anxiety and depression. Thayer (2001) also suggests that food is used for emotional self-regulation, self-medication, and personal satisfaction. In support of this, a study utilising food diary reported that teachers and nurses increased their energy intake during stressful weeks compares to less stressful weeks (Steptoe et al., 1988). In a systematic review examining emotions and eating behaviour in average weight and overweight adults, Devonport et al. (2017) noted that discrete emotions such as depression, sadness, and stress prompted poorer nutritional choices and increased food consumption.

Devonport et al.'s (2017) systematic review reveals a noteworthy pattern: food consumption is more likely to occur in response to positive affect than negative affect, indicating a connection between positive moods and heightened food intake (Cardi et al., 2015). This observation aligns with the study conducted by Bongers et al. (2013), where the effects of induced neutral, negative, and positive moods on food consumption were investigated among emotional and non-emotional eaters. A particularly interesting finding emerged – emotional eaters displayed an increased food intake during positive moods compared to neutral moods, whereas non-emotional eaters exhibited no discernible difference.

However, EE as a response to positive and/or negative emotions can be problematic and thus lead to weight gain and other health-related diseases (Péneau et al., 2013). The wide variety of emotional triggers suggests that the EE experience can differ for every individual (Devonport et al., 2017; Fuente González et al., 2022), with the intensity of emotions (such as sadness or joy) influencing the motivation to eat and eating responses (Fuente González et al., 2022). For example, a recent systematic review reports that hyper-palatable energy dense foods in are consumed in response to positive emotions for pleasure, whilst such foods consumption in response to negative emotions is often for instant reward/relief and hedonic pleasure (Fuente González et al., 2022). In better understanding emotional eating, it is necessary to examine the influences on emotional eating.

2.3 Influences on Emotional Eating

The examination of emotions and eating behaviour has been guided by various theories which pertain to influences in accordance with their focus as follows: 1) physiological/biological, 2) psychological, and 3) psychosocial focussing on cultural influences. It is important to recognise that research of EE developed from an attempt to explore and explain obesity, therefore majority of theories and research focus on obese individuals (Nguyen-Rodriguez et al., 2009).

2.3.1 Physiological/biological influences

Physiological factors influencing EE encompass the brain, neurotransmitters, hormones, hedonic systems, and metabolic pathways maintaining homeostasis (Siren & Sanlier, 2018). Lutter and Nestler (2009) highlights two influential systems: hedonic and homeostatic. The latter regulates energy balance, intensifying food consumption motivation and depleting energy stores. Conversely, hedonic or reward-driven eating arises from the urge to consume palatable foods, often overriding homeostasis, especially amid energy abundance (Lutter & Nestler, 2009).

Research indicates that reliance on specific nutrients might signify dopamine insufficiency (Siren & Sanlier, 2018). For instance, Davis et al. (2008) demonstrated that in obese individuals, overeating serves as a compensatory mechanism to regulate extracellular dopamine levels. This implies that excessive consumption of highly palatable foods acts as an alternative route for biologically augmented dopamine activation in those with deficient dopamine. Such individuals might rely on external sources like high-fat and high-sugar foods (rich in glucose and sucrose) to offset inadequate dopamine levels and experience happiness, as these food combinations stimulate opioid and dopamine secretion (Güleç Öyekçin & Deveci, 2012; Siren & Sanlier, 2018).

Kaplan's obesity theory (1957) posits that obese individuals may struggle to accurately distinguish between true physiological hunger cues and emotional cues, leading them to eat in response to emotions rather than genuine physiological needs. This perspective suggests that individuals may lack intrinsic awareness of hunger signals and instead rely on external cues to determine when and how much to eat (Serin & Sanlier, 2018). Kaplan's theory underscores the significance of counselling practitioners seeking to enhance an individuals' awareness and understanding of their internal experiences, and emotions, in order to allow exploration of, and encourage use of alternative emotion regulation strategies. However, whilst Kaplan's theory is not without limitations. One notable limitation is that the theory may inadvertently overemphasise individual responsibility for managing EE behaviours, neglecting broader systemic factors and the intersectionality of these (Van Strien, 2013). Factors including gender, race, socioeconomic status, and cultural influences in shaping individuals' experiences with EE (Schaumberg et al., 2016). It is important to take such considerations into account in order to develop an inclusive and effective intervention in addressing EE.

Building on Kaplan's obesity theory (1957), Bruch (1973) posits that confusing physical hunger with internal arousal states stems from early learned breastfeeding experiences, combining the sensation of satisfying hunger with emotional care and comfort. This confusion contributes to difficulties in regulating eating behaviours, creating a cycle of maladaptive eating patterns. Bruch's theory emphasises the importance of therapeutic exploration to uncover the underlying emotional, cognitive, and behavioural patterns contributing to EE (Bruch, 1962).

By fostering self-awareness and facilitating emotional processing, individuals can gain insight into their eating behaviours and develop more adaptive coping strategies. In the context of counselling psychology, therapists can employ Bruch's insights to tailor interventions that specifically address the emotional and cognitive aspects of emotional eating. Integrating therapeutic techniques that promote self-awareness and emotional processing, such as CBT or mindfulness-based interventions (Kristeller & Wolever, 2010), can be instrumental in breaking the cycle of maladaptive eating patterns and promoting healthier coping mechanisms. However, Bruch's theory has faced criticism, particularly in terms of its limited empirical validation and applicability across diverse populations and contexts (Fairburn & Brownell, 2002; Legenbauer et al., 2018; Lipsey & Wilson, 2001). The theory's emphasis on early learned experiences and internal arousal states may inadvertently contribute to stigmatising individuals struggling with EE. By attributing EE behaviours primarily to early life experiences, the theory might oversimplify the complex and multifaceted nature of EE. This oversimplification can lead to a reductionist view, implying that individuals are solely products of their past and ignoring the influence of current environmental, social, and cultural factors (Reichenberger et al., 2020).

Moreover, the focus on internal arousal states could inadvertently perpetuate the misconception that individuals should be able to regulate their emotions and eating

behaviours independently, without considering external influences. Such a viewpoint may contribute to the stigmatisation of those struggling with EE by placing undue responsibility on the individual, overlooking systemic factors and societal influences that also play a crucial role in shaping behaviours.

In summary, the emphasis of these theories on the misinterpretation of hunger signals may present a reductionist perspective, oversimplifying the multifactorial nature of EE and failing to account for the diverse factors that influence individuals' experiences with food and emotions. This includes environmental influences, social dynamics, and systemic barriers that shape individuals' eating behaviours and emotional responses (Bacon, 2010; Macht, 2008). Finally, these theories predominantly focus on clinical cases when investigating EE (McCullough, 2003), thereby limiting their applicability to community populations and potentially overlooking the broader causative factors contributing to EE in the general population.

Physical theories offering an alternative explanation for EE, propose that consuming high-fat and sugar comfort foods can alleviate stress by triggering the brain's reward centres, thus reducing stress response in the hypothalamic-pituitary-adrenal axis (Adam & Epel, 2007). They further argue that this phenomenon is reward-based. Jacques et al. (2019) conducted research on animals and humans, supporting the link between physical and emotional distress and increased consumption of high-sugar, high-fat foods. This is attributed to elevated cortisol and insulin levels resulting from distress (Ulrich-Lai et al., 2011). Sugary foods' impact is akin to that of social drugs, activating the mesocorticolimbic system (Kalon et al., 2016).

To expand on this, consuming high-sugar foods triggers endogenous opioids within the nucleus accumbent, activating the dopaminergic reward system similar to substances like cocaine (Lerma-Cabrera et al., 2016). This mirrors the impact of other highly addictive

substances, including cocaine (Lerma-Cabrera et al., 2016). Therefore, this illustrates the addictive potential of certain types of foods (Foran et al., 2015) and suggests that food addiction can play a role in overeating and obesity. However, while shared brain mechanisms exist between addiction and food consumption, variations exist, and much food addiction research employs animal models (Ziauddeen et al., 2012). That said, there is overwhelming evidence that sucrose consumption leads to pathophysiological consequences (Jacques et al., 2019). This includes alteration of emotional processing and morphological neuronal changes in human and rodent models.

EE emerges from the aim to alleviate stress, regulated by the hypothalamic-pituitary-adrenal (HPA) axis (Van Strien et al., 1986). Sugary foods tend to mitigate HPA axis activation, releasing stress-reducing hormones upon consumption. This lowers stress-related emotions, fostering a craving for such "comfort" foods known as "conform" foods (Yamanaka et al., 2000; Quinones et al., 2018). These outcomes increase the desire for sugary comfort foods and perpetuate EE habits (Ulrich-Lai et al., 2011; Ursano et al., 2009). To add, research indicates that ghrelin, a hunger hormone, may influence the consumption of high-sugar or high-fat foods (Quinones et al., 2018; Yamanaka et al., 2000). Pardak, Filip, and Wolinski (2022) discovered that in normal weight individuals, plasma ghrelin levels experience pre-prandial increases, followed by post-prandial decreases during the day; at night, levels rise, then decline until morning. However, ghrelin levels in obese individuals seem lower compared to those with normal weight, possibly due to chronic overeating suppressing ghrelin secretion, or potentially linked to common hyperinsulinemia in obesity.

The link between Ghrelin, sleep and obesity has been evidenced in various studies as captured in a systematic review conducted by Senaratna et al. (2017). In a further link between ghrelin and EE, there is evidence sleep deprivation increases ghrelin levels, and promotes hedonic eating via the intake of highly palatable foods (Cain et al., 2015; Pardak et

al., 2022). It is worth noting that Cain et al. (2015) focused on night shift workers, while Pardak et al. (2022) studied overweight and obese individuals, limiting generalisation to non-clinical populations.

To conclude, the explanation provided for EE from a physical perspective offer valuable insights into the neurobiological mechanisms underlying the consumption of high-fat and sugar comfort foods in response to stress and emotional distress (Adam & Epel, 2007). However, physical theories which predominantly focus on the neurobiological considerations may also oversimplify the multifaceted nature of emotional eating, which as previously noted encompasses psychological, emotional, social, and environmental factors (Bacon, 2010). Additionally, cultural influences play a significant role in shaping individuals' eating behaviours and emotional responses, with cultural norms, values, and practices influencing food choices, eating patterns, and the perception of emotions and stress (Sobal & Wansink, 2007). While animal studies provide valuable insights, the generalisation of findings from animal models to human behaviour may not always be straightforward due to species differences in neurobiology, behaviour, and cognition (Ziauddeen et al., 2012).

Furthermore, the emphasis on the addictive potential of certain foods and the comparison with substances like cocaine may inadvertently contribute to stigmatising individuals struggling with EE and obesity, reinforcing negative stereotypes and undermining efforts to foster compassion and support (Foran et al., 2015). The focus on neurobiological mechanisms may also overshadow the role of other contextual factors, such as socio-economic status, psychological factors, and systemic barriers, in shaping individuals' eating behaviours and emotional responses (Macht, 2008). Additionally, while there is evidence linking high-sugar consumption to alterations in emotional processing and neuronal changes, establishing a causal relationship between these factors and EE and obesity requires further research and consideration of confounding variables (Jacques et al., 2019). EE is a complex

behaviour influenced by a myriad of factors, including genetics, environment, psychology, physiology, and cultural influences. A holistic understanding of EE necessitates an integrated approach that considers the multifactorial nature of this behaviour, fostering a nuanced and compassionate perspective within the field of counselling psychology.

2.3.2 Psychological influences

Numerous theories aim to explain the psychological factors underlying and sustaining EE. For instance, the EE theory (EET Bruch, 1973; Slochower, 1983) presents two primary assumptions. First, unpleasant emotions heighten the motivation to eat, characterised by strong cravings leading to increased food intake. Second, food consumption diminishes the intensity of unpleasant emotions. This association could lead individuals to perceive food as a means to alleviate emotional distress and gain satisfaction, fostering an unhealthy food-emotion relationship. Given that emotions drive such eating behaviours beyond satiety and hunger cues, this inclination can contribute to overweight and obesity (Bruch, 1973; Kaplan & Kaplan, 1957).

Drawing upon both learning and psychodynamic principles, affect phobia theory offers a nuanced understanding of the complex interplay between emotions, maladaptive behaviours, and psychological factors in the context of EE. Central to affect phobia theory is the concept of emotional phobia, where individuals may develop fears or aversions to experiencing and expressing certain emotions due to early life experiences or socialisation processes (Malan, 1995; Power & Dalgleish, 1977). In such cases, emotional expression may be inhibited or restricted, leading to a dissociation of emotions from the self and creating a vulnerability to maladaptive coping strategies such as EE (Fox & Power, 2009).

Moreover, affect phobia theory emphasises the role of secondary emotions such as shame or guilt in perpetuating the cycle of EE, suggesting that individuals may experience

negative emotions towards themselves following episodes of EE, which in turn may trigger further episodes of EE as a maladaptive coping response (McCullough, 2003). This highlights the need for interventions that address both the underlying emotional phobias and the negative self-perceptions that may contribute to the perpetuation of EE. The affect phobia theory offers a more nuanced understanding of the role of emotions in eating behaviours, emphasising the interplay between emotional regulation, maladaptive behaviours, and psychological factors compared to EE theory (Booth, 1994; McCullough, 2003).

The affect phobia theory partly overlaps with the EE theory (Bruch, 1973), proposing that the rewarding emotional consequences of eating in response to unpleasant emotional experiences gradually reinforce such behaviour through operant conditioning (Booth, 1994; Hawkins & Clement, 1984). This sustained behavioural pattern of resorting to food during unpleasant emotions can eventually become a classically conditioned response, motivating eating when such emotions are triggered (Nyklíček et al., 2011). Using food as an affect regulation strategy involves antecedent and response-focused approaches. An antecedent-focused strategy occurs before the activation of the emotional response, altering behavioural and physiological reactions. Cognitive reappraisal is an antecedent-focused strategy that aims to reshape an individual's perception of an emotional situation to modify its emotional impact. Mischel and Ayduk (2004) consider this a 'cooling' technique as it provides distance from the unpleasant situation, supporting a reduction in negative emotions. Research also indicates that distraction and engaging in alternative activities can aid in self-control (Gross & Thompson, 2007), suggesting its effectiveness in evading situations where temptation to eat may arise.

A response-focused strategy comes into play after the emotional response is triggered by an emotional stimulus (Gross & John, 2003). Expressive suppression is a response-focused strategy that aims to diminish emotions by controlling complex emotions associated

with reduced emotional expression (Gross, 2002). EE and resorting to food to avoid directly confronting emotions can be seen as an expressive suppression strategy.

While affect phobia theory provides insights into the possible psychological mechanisms underlying emotional eating, empirical support for the affect phobia theory has been equivocal, highlighting the need for further research to explore and test its theoretical propositions (Echeverri-Alvarado et al., 2020; Breland et al., 2018). Empirical validation is fundamental to establishing the credibility and reliability of a theoretical framework, as it involves systematic investigation and empirical evidence to support the proposed hypotheses and theoretical constructs (Echeverri-Alvarado et al., 2020). The applicability of affect phobia theory may be influenced by cultural factors, such as cultural norms, beliefs, and values surrounding food and emotions, which can shape individuals' experiences and expressions of EE across diverse cultural contexts. Moreover, the findings derived from studies focusing on specific populations, such as clinically overweight and obese adults engaged in weight management programs, may not be fully generalisable to the broader population. The unique characteristics and dynamics inherent within such contexts may limit the broader applicability of these findings, warranting caution when extrapolating these conclusions to diverse populations and settings (Fox, Conneely & Egan, 2017; Echeverri-Alvarado et al., 2020).

Furthermore, the distinction between binge eating and EE is pivotal in interpreting and contextualising the findings related to the relationship between negative emotions and eating behaviours. Binge eating and EE, although related, encompass distinct patterns and motivations underlying food consumption in response to emotional triggers (Breland et al., 2018). Binge eating is characterised by episodes of excessive food consumption accompanied by a sense of loss of control, whereas EE refers to the consumption of food in response to emotional cues, such as stress, sadness, or anxiety (Svaldi et al., 2019). The assertion that

unpleasant emotional states are improved following binge eating has been challenged, highlighting the need for a more nuanced understanding of the underlying psychological mechanisms and contextual factors influencing this relationship (Breland et al., 2018; Lim et al., 2021). Moreover, the caveat that this conclusion primarily pertains to binge eating and may not necessarily extend to EE in non-clinical populations emphasises the importance of distinguishing between different eating behaviours and their respective implications for affect regulation and psychological well-being (Arexis et al., 2023; Breland et al., 2018). It underscores the need for comprehensive and context-specific approaches to studying and addressing EE within diverse populations, taking into account the multifaceted nature of eating behaviours, emotional experiences, and cultural influences.

A final psychological theory presented for review is restraint theory (RT) which posits that dieting may contribute to disorder eating, as restrained eaters cognitively limit food intake without reducing actual consumption compared to non-restrained eaters (Herman & Polivy, 1980; Stice et al., 2007). Strict rules and minor violations can lead to cognitive disruption, prompting excessive consumption, followed by restarting the diet the next day (Mills & Palandra, 2008). RT suggests that perceptions of dietary violations prompt restrained eaters to abandon their diet and overeat, especially when breaking rules or experiencing unpleasant emotions (Cardi et al., 2015; Herman & Mack, 1975). Research indicates that restrained eaters consume more food when breaking diet rules and when experiencing unpleasant emotions, potentially because these emotions deplete the cognitive resources needed for adhering to dietary restrictions (Cardi et al., 2015; Herman & Mack, 1975). While studies support RT (Costa et al., 2022; Schnepper et al., 2020), it is essential to critically evaluate its applicability and limitations across diverse populations and cultural contexts. RT's cultural bias and limited generalisability raise concerns about capturing

complex sociocultural factors influencing eating behaviours and body image perceptions (Van Strein, 1999; Williams et al., 2002).

To conclude, the predominant focus on clinical populations and weight management programs questions the generalisability of psychological theories, as studies often draw participants from biased samples (Echeverri-Alvarado et al., 2020; Fox, Conneely & Egan, 2017). The link between EE and mood enhancement challenges the assumption that EE is solely connected to negative emotions, highlighting individuals' inadequacy in employing adaptive emotion regulation strategies (Evers et al., 2010). Cultural factors also influence individuals' experiences and behaviours related to food, emotions, and body image, affecting the applicability of theoretical frameworks like affect phobia theory across diverse cultures (Mintz & Du Bois, 2002; Nasser, 1988). Varying cultural norms, values, and beliefs influence how individuals relate to food and experience EE. In cultures where food holds social, religious, or symbolic meanings, and specific body image ideals exist, individuals' EE experiences are shaped by these cultural factors (Matsumoto, 1990; Tsai, 2007). Differences in emotional expression norms, particularly in cultures emphasising restraint or stigmatising emotions, may lead to increased EE as a coping mechanism, challenging the application of theories like APT (Matsumoto, 1990; Tsai, 2007).

There is a need in counselling psychology to recognise the influence of cultural factors, including adapting therapeutic interventions to be culturally sensitive, responsive to individuals' backgrounds, beliefs, and experiences, and integrating cultural considerations into the assessment and treatment of EE to enhance intervention relevance and effectiveness across diverse cultural backgrounds.

2.3.3 Psychosocial influences

In discussing psychosocial influences, particularly pertinent to the current research is the emphasis on cultural influences. Defining culture is intricate, encompassing four distinct meanings: 1) an intellectual and artistic framework, 2) a source of intellectual and spiritual growth, 3) the beliefs, values, symbolism, and customary practices that facilitate collaboration among individuals; 4) a comprehensive way of life (Eagleton, 2016). The operational definition of culture adopted in this research program aligns with the notion of "*the collective programming of the mind which distinguishes the members of one group from another."* This definition guides the ongoing research, consistent with researchers' epistemological perspectives (Hofstede, 1980, pp. 21-23). Culture is proposed to function internally and externally, influencing the construction of meaning and behaviour (Hong et al., 2000). Moreover, culture evolves in response to environmental changes, shaping adaptive beliefs, practices, and behaviour (Kitayama et al., 2010). This implies that cultural principles can evolve across generations and underscores the existence of diverse cultures.

Recognising cultural influences is vital for investigating emotions, their regulation, emotional eating, and obesity prevention (Leersnyder et al., 2015). Given food's inherent role in daily life, it holds psychological, social, economic, and cultural significance for all individuals. Regarding emotions and their regulation, Lim (2016) delved into emotional arousal preferences and experiences among Western and Eastern populations. Lim's findings indicated that participants from Western cultures experienced high-arousal emotions (like fear, alarm, annoyance, anger, happiness, or tension) more frequently compared to Eastern culture populations. Conversely, Eastern cultures favoured and experienced low-arousal emotions (such as peace, relaxation, ease, or boredom) more prominently than high-arousal emotions (Lim, 2016). This suggests that culture shapes how emotions are exhibited and felt within specific cultural contexts, influencing individuals expected emotional responses during

particular events (Luomala et al., 2009). Research also highlights that in Middle Eastern cultures, emotions are often linked to interpersonal relationships, emphasising group affiliations (family/tribe), prompting individuals to regulate emotional expression to preserve social ties (Al-Qarni, 2019).

Building on this, cultural differences extend to mental health literacy, particularly evident in stigmatising notions about the origins of poor mental health within Arabic society. This encompasses medical students, mental health professionals, and Paediatric hospital staff (Alahmed et al., 2018; Krstanoska-Blazeska et al., 2021). Stigma involves expressing emotional reactions, behaviours, and negative cognitions, posing significant challenges, particularly within Middle Eastern cultures. Stigmatising beliefs encompass attributing mental health symptoms to malevolent supernatural forces (Jinn/devil) and associating mental illness with a lack of faith or sins committed. These convictions result in mental health challenges being perceived as detrimental to family/tribal reputation, social status, and family honour (Krstanoska-Blazeska et al., 2021). As a result, stigmatising beliefs in the Middle East hinder professional assistance for mental health issues (Dardas & Simmons, 2015). This, combined with negative attitudes towards seeking help, gender role expectations, religious factors, and cultural barriers, leads to prevalent emotional suppression and repression in this population (Lim, 2016; Tahmouresi et al., 2014; Zolezzi et al., 2018).

Individuals employ a range of adaptive and maladaptive regulatory strategies, the latter linked to psychopathology (Aldao & Nolen-Hoeksema, 2012). Adaptive strategies encompass acceptance, cognitive reappraisal, problem-solving, positive refocusing, and positive reappraisal (Kobylińska & Kusev, 2019). Conversely, maladaptive strategies involve self or others blame, catastrophic thinking, suppression, or overeating (Garnefski et al., 2001). Espeset et al. (2021) note that emotional overeating, often seen in coping with aversive emotions, may stem from deficient adaptive strategies. Suppression, notably used by

Middle Eastern women (Kobylińska & Kusev, 2019), correlates with severe EE in adults (Kobylińska & Kusev, 2019; Ferrer et al., 2017; Racine et al., 2019; Sultson & Akkermann, 2019) and adolescents (Ferrer et al., 2017; Vandewalle et al., 2016). This link between emotional suppression and EE is salient in Middle Eastern contexts (Dardas & Simmons, 2015; Krstanoska-Blazeska et al., 2021; Zolezzi et al., 2018).

Investigating the adoption of suppression by Middle Eastern women, reports reveal feelings of shame and embarrassment in seeking support and a reluctance to express emotions within this group (Krstanoska-Blazeska et al., 2021). Tahmouresi et al. (2014) found that among 269 children from Iran and Germany, Iranian children exhibited challenges in emotive expression, possibly linked to cultural norms emphasising respect and family harmony.

Food holds fundamental importance in culture, traditions, religion, and socialisation globally (Ahmed, 2002; Chavez et al., 1994; Crane & Green, 1980; Gordon et al., 2000; McArthur et al., 2001; Kim et al., 1984; Story & Harris). Sharing meals is a ritualistic act in Arabic food culture (Stephenson & Ali, 2018), embodying expressions of love, friendship, generosity, and hospitality through the provision of food, including its type and quantity (Kulwicki & Ballout, 2013). Hospitality's value is often gauged by the offering of diverse foods, including high-quality items such as rice, meat (lamb or bull), coffee, dates, buttermilk, and fruits (Stephenson & Ali, 2018).

Food symbolises hospitality and is considered a representation of divinity, as observed in Christianity and Islam where virtuous behaviour signifies being in God's presence (Siddiqui, 2017). The host's etiquette dictates being the first to commence eating and the last to conclude (Mermelstein, 1999; Sakr, 1975), signifying an invitation for guests to dine at their pace without feeling compelled to stop. This custom obliges hosts to persist in eating, even if full, until guests have finished. In a study of Qatari women's lifestyles, social hospitality and politeness emerged as pivotal attributes in their interactions during gatherings

and domestic occasions, leading them to often feel compelled to consume unhealthy foods, recognising them as suboptimal choices (Donnelly et al., 2011).

Middle Eastern women often view meal preparation and presentation as an expression of care and affection for their families (Al-Bkerat, 2019). Sharing meals is an essential practice, with wives and mothers expected to dine alongside children, husbands, and guests, signifying respect and warmth (Assaad et al., 2017). Culinary offerings upon family members' requests bestow symbolic authority (Vallianatos & Raine, 2008), and although Arabic and South Asian participants typically prefer traditional fare, they adapt by preparing Western dishes for their children's preferences (Vallianatos & Raine, 2008). This scenario results in the simultaneous preparation of distinct meals, a common occurrence among immigrants (Vallianatos & Raine, 2008; Trofholz et al., 2020), possibly leading to exceeding the recommended three daily meals. Moreover, communal eating engenders overconsumption, driven by the absence of perceived necessity to restrict intake in order to present a favourable impression (Higgs et al., 2022). This underscores the necessity of grasping food's symbolic significance and cultural associations for understanding individuals' subjective experiences and the delineation of socio-cultural boundaries.

In conclusion, it is evident that culture exerts a significant influence on the shaping of an individual's thoughts, beliefs, and behaviours, encompassing the realm of emotional regulation and the management of emotions. Diverse cultural principles contribute to this phenomenon, such as the emphasis on group cohesion inherent in collectivist cultures as opposed to the individualistic pursuits more common in individualistic cultures. Moreover, cultural norms, etiquettes, gender roles, attitudes towards mental health, religious beliefs, and societal norms collectively contribute to this complex interplay. Consequently, these cultural factors can exert a discernible impact on EE behaviours and the broader landscape of emotional management.

2.4 Importance of Understanding Culture

Research has illustrated the influence of culture on individuals' EE patterns, emphasising the need for a nuanced exploration of cultural influences. Cultural norms, values, and practices play a pivotal role in shaping how individuals perceive and cope with emotions, with food often serving as a significant coping mechanism (Luomala et al., 2009). However, there is little research regarding the diverse ways in which people from different cultures regulate their emotional experiences through distinct eating patterns. An individuals' cultural background influences various aspects of their food intake, encompassing factors including religion, upbringing, family circumstances, and perceptions of weight status; all of which intricately shape self-image and beliefs. In certain cultures, such as those in the Middle East, seeking professional help for psychological or physical changes associated with obesity may be discouraged due to cultural attitudes, particularly concerning the roles of women and the sensitivity of personal topics discussed outside the cultural group (Dardas & Simmons, 2015).

The influence of culture on the provision of psychological care cannot be overstated, it profoundly shapes the therapeutic process for individuals from varied cultural backgrounds (Marzilli, 2014). As a pivotal factor influencing cognition and behaviour, culture significantly influences the dynamics of therapeutic relationships and, consequently, treatment outcomes (Wang, 2017). In light of this, there is a growing emphasis on the importance of cultural awareness among therapists, with scholarly literature advocating for the adaptation of evidence-based therapeutic approaches to be more culturally congruent (Banuto et al., 2019; Soto et al., 2018). A significant concern is the potential for therapists, particularly those trained within Western paradigms, to have limited understanding or awareness of indigenous cultural contexts (Gucchi, 2022). This lack of cultural competence can inadvertently lead therapists to apply Western-centric conceptualisations and therapeutic techniques, which may not only be ineffective but could also be discordant with the cultural beliefs and values of

non-Western clients (Fernando, 2014). Non-Western psychologies often encompass rich spiritual, religious, and philosophical dimensions that may not align with the secular, dualistic frameworks commonly utilised in Western therapeutic practices (Cucchi & Fernando, 2014).

This critique identifies the need for a more nuanced and culturally sensitive approach to psychological care, one that acknowledges and respects the diverse cultural landscapes within which therapy occurs. Understanding the profound influence of culture extends beyond research it directly informs the provision of care tailored to the unique needs of individuals from diverse cultural backgrounds (Marzilli, 2014). Culture, as a fundamental determinant of cognition and behaviour, plays a critical role in therapeutic relationships and treatment outcomes (Wang, 2017). Therapists are increasingly recognised for the importance of cultural awareness, with literature advocating for the cultural adaptation of evidence-based therapy modalities to enhance therapeutic relationships (Banuto et al., 2019; Soto et al., 2018).

Individuals who receive culturally responsive mental health care report increased utilisation, better treatment retention, and higher overall satisfaction with their care compared to those without such cultural responsiveness (Meyer & Zane, 2013; Rathod et al., 2010). Notably, Wang (2017) highlights the potential pitfalls of imposing dominant Westernized models of psychology on diverse populations, emphasising the risk of drawing hasty and inaccurate conclusions. For instance, individuals from collectivist cultures, such as those in the Middle East, may exhibit different communication styles, potentially impacting their interactions with therapists (Kim, 2015). Recognising non-verbal cues becomes crucial in such contexts, as clients from collectivist cultures may be less likely to express disagreement verbally. Additionally, cultural nuances can manifest in varying attitudes toward engaging

with tasks, disclosure of symptoms, and preferred modes of communication (Williams et al., 2016; Mooney et al., 2016). The imperative for healthcare professionals is clear: to enhance outcomes, cultural understanding must be integrated into interventions and communication strategies, acknowledging and respecting clients' cultural preferences (Harrison et al., 2019; Linnard-Palmer, 2017; Harrison et al., 2016).

In the present study, interview questions for phase one were designed to account for and allow discussion of the ten culture categories for micro and macro understanding proposed by Moran et al. (2011), particularly when exploring cultural experiences and influences on emotional eating. Although these 10 categories were initially designed for business, they have subsequently been used in education (Weda et al., 2022) and healthcare contexts (Harrison et al., 2019; Ivkovic & Knezevic, 2022; Linnard-Palmer & Ngo, 2015). Moran et al. (2011) advocate the use of these categories regardless of whether a population of interest lives in the "rural south of the United States, India, the bustling city of Hong Kong, Bangalore, Arusha in Tanzania, or Baghdad in Iraq" (p. 11). The rationale for utilising these ten categories is that research indicates that effective cultural engagement enhances healthcare quality in various ways, including accounting for individuals' beliefs, values and preferences and contributing to patient-centred care through supportive decision-making concerning screening, and treatment and care options, which is in line with the aims of the current programme of research (Harrison et al., 2019). Furthermore, there is evidence that consumers from ethnic minority ethnicity face various obstacles when engaging with healthcare services, compounding existing healthcare inequities (Blom et al., 2016; Harrison et al., 2019). As such, it suggests that culturally competent healthcare provision is central to realising the patient centre care agenda for individuals from minority cultures (Moran et al., 2016).

The ten categories are as follows:

1) **Work habits and practices**: Encompassing attitudes towards work, its types, divisions, and associated habits, vary across cultures. In some societies, the involvement of all family members in work is expected, while in others, this norm may not apply. For instance, the Middle Eastern region exhibits the largest economic gender gap globally, with female labour force participation estimated at only 20% (The World Bank, 2019). This discrepancy is influenced by cultural beliefs, social norms, discrimination, poor job conditions, and misinformation.

When examining the experiences of women from Arab countries who have migrated to westernised countries. Cultural norms emphasising the prioritisation of children and household responsibilities over work may present challenges for these women. Research indicates that the expectations surrounding women's roles can clash with the requirements of the Western workplace (Hakim, 2011; Platt et al., 2016). The traditional emphasis on women primarily focusing on familial duties might lead to stress and boredom, potentially contributing to emotional eating patterns (Cancian et al., 2019; Fuente González et al., 2022; Manchon et al., 2021).

2) **A sense of self or space**: The concept of a sense of self or space varies across cultures, with some societies valuing a humble demeanour and others endorsing more assertive, macho behaviour. Cultural norms also influence the level of flexibility and formality within interpersonal interactions. For instance, Latin and Arab cultures often emphasise proximity and staying close together, while Westernized cultures tend to prefer a sense of personal space and distance (Moran & Moran, 2011). Research suggests that the cultural inclination to stay close together can have implications for emotional expression and regulation. While maintaining closeness can foster harmony, it may also exert pressure on individuals to suppress emotions to maintain group cohesion (Kitayama et al., 2006). This phenomenon is particularly relevant when considering non-Western individuals and the factors influencing

their sense of self and space. Studies on non-Western populations highlight the significance of cultural factors in shaping one's sense of self and space. Research has explored how societal expectations and cultural norms impact emotional expression, with a focus on the potential consequences of suppressing emotions in collectivist cultures (Matsumoto, Yoo, & Nakagawa, 2008). This may then lead to maladaptive ways of coping with difficulties such as EE (Fox & Power, 2009).

3) **Dress and appearance**: The significance of dress and appearance, including adornments, outward clothes, and culturally distinctive body decoration, varies across cultures. In some cultures, maintaining an appropriate dress code is considered important, reflecting societal values and norms. For instance, a systematic review by Masri, Kolt, and George (2021) of qualitative studies exploring the factors influencing the physical activity levels of Arab migrant women, in particular, raised concerns regarding maintaining modesty in public settings, as some activities performed in public were inappropriate for Muslim women. With respect to dress codes, some Arab migrants were embarrassed or feared judgment when wearing certain types of clothing for physical activity, or other non-traditional dress codes were deemed inappropriate (Ali, 2015; Nasser, 2011).

4) **Time and time consciousness**: The sense of time varies significantly between cultures; some cultures emphasise a relative approach to time, while others adhere to a more exacting schedule. For example, in Western culture, individuals are generally precise about time, while members of Latin and Arabic cultures tend to adopt a more casual attitude. These diverse cultural perceptions of time may not only impact daily routines and stress levels but also influence time-related eating patterns, potentially contributing to EE behaviours.

The cultural nuances surrounding time extend to the preparation and synchronisation of meals, as reported by numerous studies conducted among immigrants (Trofholz et al., 2020; Vallianatos & Raine, 2008). This cultural influence on meal preparation practices,

where different meals must be prepared simultaneously, adds an additional layer to the complex interplay of cultural factors affecting eating patterns and family routines, thereby influencing EE behaviours.

5) **Values and norms**: are determined by cultural needs, including priorities assigned to some behaviour within the group. Culture sets the norm of a particular behaviour for the society, and the acceptability may range from work ethic to absolute obedience or equal relationship in marriage to rigid submission of the wife to her husband. According to Zahr & Hattar-Pollara (1998), within the Arab culture, the family is the strongest unit and foundation on which the society is built. Within the Arabic culture, being healthy means being able to perform daily routine demands without physical complaints and pain (Al-Bkerat, 2019). Core cultural values within Middle Eastern societies, such as family commitment and responsibilities, may contribute to emotional eating patterns as individuals navigate their roles and obligations (Al-Bkerat, 2019).

6) **Beliefs and attitudes**: Religious traditions within the Middle Eastern culture can consciously or unconsciously shape an individual's attitude and beliefs towards life. Core values such as honour, loyalty, responsibility, family commitment, obligation, and unity play a significant role and may vary based on gender (Al-Bkerat, 2019). For instance, traditional beliefs linking mental distress to supernatural forces like jinn or religious transgressions present substantial barriers to seeking and engaging with Western psychological treatments (Al-Krenawi & Graham, 2000; Nassar-McMillan & Hakim-Larson, 2003). These beliefs not only contribute to stigma but also influence treatment preferences and adherence, as individuals may fear social repercussions, including being labelled as 'crazy' or having 'weak faith' (Al-Krenawi & Graham, 2000). This may also lead to maladaptive coping strategies such as overeating (Fox & Power, 2009; Reichenberger et al., 2020)

7) **Communication and language**: Effective communication serves as a defining factor across cultural groups, involving both verbal and non-verbal dimensions. In Middle Eastern communities, there is a notable trend towards the use of suppression and repression as mechanisms for managing emotional expression (Dardas & Simmons, 2015; Krstanoska-Blazeska et al., 2021). This nuanced emotion regulation style has been associated with distinctive patterns of EE within this cultural context (Zolezzi et al., 2018).

8) **Food and feeding habits**: this includes food selection, preparation, presentation and eating, which tends to differ between cultures. For example, Americans citizens commonly consume beef; however, to some Hindus, this is forbidden. While pork is eaten by the Chinese and others, it is forbidden for Muslims and Jews. In Arabic culture, food, particularly sweets, is often used to reward good behaviour (Al-Bkerat, 2019).

Middle Eastern women often view meal preparation and presentation as an expression of care and affection for their families (Al-Bkerat, 2019). The cultural significance of food, representing hospitality and divinity (Siddiqui, 2017), can pose challenges. In a study focusing on Qatari women's lifestyles, the emphasis on social hospitality and politeness emerged as crucial. However, this cultural norm sometimes led these women to feel obligated to consume unhealthy foods, acknowledging them as suboptimal choices (Donnelly et al., 2011). This highlights a potential conflict between cultural practices, societal expectations, and individual health considerations within Middle Eastern contexts.

9) **Relationships**: culture influence human and organisation relationships by gender, age, degree of kindred, wealth, status, power, and wisdom. For example, in family units where in some cultures living with in-laws or with your elderly is a norm. For Middle Eastern populations, food is considered a fundamental part of socialisation and connecting family or people which can be a positive, but for Middle Eastern women this can present a barrier in seeking to manage EE.

10) **Mental processing and learning**: include the way in which people organise and process information within different cultures. For example, Scaglione et al. (2018) suggests that dietary habits and practises are shaped at a young age and often maintained later in life. This means that established eating behaviours during childhood may carry through to adulthood with consequences such as poor dietary variety, fussiness, or high receptiveness to food cues and increase risk of obesity. To add. early learning experiences and cultural shaping of dietary habits may influence the development of emotional eating patterns, emphasising the role of cultural factors in mental processing related to food (Scaglione et al., 2018), also support by Bruch's (1973) theory of EE.

For this programme of research, these ten categories were considered in seeking to understand cultural experiences of EE among Middle Eastern women, particularly during thematic analysis as used in phase one.

2.5 Emotional Eating Interventions and Cultural Adaptation Needs

There are a variety of psychological interventions that have been used to help individuals manage their emotional eating, however, for the purpose of this programme of research, CBT in explored in further detail for several reasons. 1) CBT has been used in seeking to help manage EE, 2) it has been widely used among collectivist cultures (Jacob et al., 2018; Naeem, 2019; Husain et al., 2020), 3) as recommend by NICE guidelines (2018) it can be delivered as brief intervention and is cost-effective, and 4) it is the therapy most commonly culturally adapted (Alatiq & Alrshoud, 2018; Berry et al., 2018; Naeem, 2019; Rathod & Degnan, 2018).

CBT interventions for EE involve improving individuals' emotional processing and thus reducing their maladaptive eating patterns, which play a vital role in weight management (Torres et al., 2020). The intervention places emphasis on emotional regulation exercises,

including food cravings, impulsive eating, emotional regulation skills and emotional functioning (Buckroyd & Rother, 2006; Pjanic et al., 2017; Preuss et al., 2017). These interventions show promising results; for instance, Torres et al. (2020) conducted an emotional-focused CBT (EF-CBT) pilot study among ten Portuguese females (seven completed the program) exploring feasibility and long-term outcomes. Emotional processing, psychological distress, weight loss, and eating behaviour were measured at baseline, six-months, and at 18-months follow-up. The results showed decreased psychological distress and positive changes in emotional processing and weight loss. Further, weight loss scores were below expectation at all points as well as the changes in external eating and emotions and restrained eating scores remained stable. The participants perceived the program to be beneficial in improving emotional awareness and eating. Finally, the program was deemed feasible based on the attendance and retention rate (70%). However, the study is limited by the small sample size (possibility of overemphasising the effectiveness of the treatment), use of middle-aged obese females' participants only, and the absence of a control group, thus limiting its generalisability. Similarly, Khan et al. (2019) utilised a culturally adapted CBT-based group intervention for south Asian women struggling with maternal depression and reported improvement in both depression and quality of life.

CBT for EE has also been found to be effective among non-western clients, with benefits attributed to its structured and goal-directed approach (Diaz-Martinez et al., 2010; Jankowska, 2019; Okazaki & Matsumi, 2010). CBT interventions with non-western individuals has been found to be more effective where the intervention accommodates cultural considerations (Alatiq & Alrshoud, 2018; Berry et al., 2018; Naeem, 2019).

As our understanding of mental health expands, a critical exploration of the impact of colonization on the field, and the limitations of traditional psychotherapy models becomes essential. Opting for adapted mental health care approaches over conventional Western-

centric methods presents significant benefits, including improved treatment outcomes, personalised plans, reduced reliance on psychiatric medications, fewer reported negative side effects, and cost savings (Martin, 2016). For instance, Safran et al. (1993) suggest selection criteria for the suitability of CBT for the general population, emphasising the ability to differentiate between thoughts and emotions, and understanding how thoughts relate to emotions. However, this distinction is rooted in Western concepts and may not universally apply, raising questions about its relevance to cultures that do not make the same clear-cut delineation between thoughts, feelings, and behaviour.

In terms of using CBT among Arab populations, there are both opportunities and challenges. Research indicates that CBT's structured and goal-oriented nature can be beneficial for individuals dealing with emotional distress (Diaz-Martinez et al., 2010; Jankowska, 2019; Okazaki & Matsumi, 2010). However, a critical perspective is necessary when acknowledging that the cultural nuances and diverse perspectives within Arab populations may not align seamlessly with CBT's Western origins. Adapting CBT interventions to incorporate cultural nuances shows promise in enhancing treatment efficacy (Alatiq & Alrshoud, 2018; Berry et al., 2018; Naeem, 2019), yet it requires careful consideration to avoid imposing Western-centric models without recognising the cultural variations in understanding and experiencing mental health. On the other hand, traditional beliefs linking mental distress to supernatural forces like jinn or religious transgressions present significant barriers to seeking and engaging with Western psychological treatments (Al-Krenawi & Graham, 2000; Nassar-McMillan & Hakim-Larson, 2003). Such beliefs not only contribute to stigma but also influence treatment preferences and adherence, as individuals may fear social repercussions, including labelling as 'crazy' or having 'weak faith' (Al-Krenawi & Graham, 2000). Furthermore, given that Western-trained health professionals often utilise explanatory models that neglect cultural and religious concepts, individuals may

feel their experiences are not accurately represented (El-Islam & Dagga, 1992). Recognising afflictions as being rooted in supernatural elements, as opposed to biopsychosocial factors (Engel, 1980), can influence how individuals seek assistance and interact with diverse services.

CBT has faced criticism for not adequately addressing religious dimensions (Imawasa & Hays, 2018). For example, Cucchi (2020) argues that Islamic principles, rooted in ontological absolutism and the belief in an absolute truth, contrasts with CBT. While CBT operates on constructive and self-determined foundations, Islam emphasises acceptance of divine planning and challenges the individual's internal control beliefs. These differences highlight potential challenges in applying traditional CBT methods directly to Muslim communities. Failing to adopt a holistic approach and recognise these differences risk excluding a portion of the population who may be concerned about their belief systems not being acknowledged or comprehended. In fact, many core tenets of prevailing perspectives in contemporary secular psychology and psychotherapy starkly contrast with those found in the Islamic narrative (Badri, 2008).

Some clinicians posit that CBT resonates more with Islamic principles as compared to other therapeutic methods (Sheik, 2018; Thomas, 2013). This resonance is linked to CBT's core idea of interconnectedness between cognitions, emotions, physical sensations, and actions, a notion echoed in Ghazali's medieval Islamic understanding of human psychology (Ghazali, 1986). Ghazali's framework outlined four intertwined human components: "aql" (intellect), "qalb" (heart), "nafs" (self), and "ruh" (spirit). The "aql" pertains to logical reasoning, mirroring CBT's emphasis on cognitions, while the "qalb" embodies emotions in a spiritual and psychological context rather than a purely biological one, acting as the foundation for comprehension and perception (Çağrıcı, 2013; Kemahli, 2017). In Arab settings, the present-focused and practical nature of CBT might offer a more acceptable

treatment option, resonating with the preference for clear, action-oriented therapies (Al-Krenawi & Graham, 2000). Studies also highlight CBT's effectiveness within Arab demographics, especially concerning issues like post-traumatic stress disorder (Stenmark et al., 2013; Wagner et al., 2012). As perceptions around mental well-being shift in Arab societies, there is growing potential for the harmonisation and success of Western therapeutic methods (Al-Krenawi, 2002; Kayrouz et al., 2014).

For example, Kayrouze et al. (2018) conducted a meta-analysis on the efficacy of Cognitive Behaviour Therapy (CBT) in Arab adult populations suffering from anxiety, depression, or PTSD. Out of nine eligible studies involving 536 participants, three were randomised control trials. The findings revealed that all studies reported a significant reduction in psychological symptoms post-treatment, with notable effect sizes for anxiety, depression, and PTSD. Six of these studies also showed that symptom reductions were sustained during follow-ups. The overall dropout rate was 26%, suggesting good acceptability. Furthermore, when CBT was delivered remotely via internet or telephone, it demonstrated comparable effectiveness to face-to-face sessions. This meta-analysis underscores the potential of CBT as a valuable intervention for treating these mental health concerns within Arab adult populations. This was supported by research indicating that CBT has comparable effectiveness in treating anxiety, depression, and panic disorder for both Arab and Caucasian participants (Al-Noor, 2017; Kayrouz et al., 2015, 2016; Wagner et al., 2008).

Whilst CBT centres on mental processes and their effects on personal experiences, Islam emphasises the soul and heart in defining one's "self" (Inayat, 2005; Keshavarzi & Haque, 2013). In the Islamic context, the heart, not the mind, is considered the core of human existence. Some experts advocate that therapists should prioritise understanding the "qalb" (heart) (Lodi, 2018; Rothman, 2018). Yet, others point out that early Islamic scholars recognised the significant role of thoughts in shaping other psychological aspects (Keshavarzi

& Khan, 2018), as previously mentioned. To reconcile these differences, it is suggested that professionals should engage both theoretically and practically. This involves: (a) Recognising and redefining psychology/psychotherapy through Islamic lenses, respecting indigenous perspectives on knowledge. (b) Enhancing theoretical models to include local understandings of the human psyche. (c) Adapting secular interventions to align with cultural sensitivities and traditions.

The following example illustrates some of these principles. Kayrouz et al. (2018) delivered an internet-based CBT program tailored for Arabs residing in Australia which demonstrated effectiveness in managing depression and anxiety. The program integrated cognitive therapy principles into the intervention, emphasising thought monitoring and challenging maladaptive thinking. Cultural adaptations included transliterating key mental health terms into Arabic, incorporating a monotheistic definition of spiritual health emphasising a trusting relationship with God, and prominently featuring Arab names in case examples and educational stories. The male case example depicted an engineer adjusting to life as a cleaner in Australia after seeking refuge from war, highlighting the loss of his previous identity. Conversely, the female case portrayed an Australian-born Arab navigating ethnic identity conflicts. The educational narratives were adapted to reflect cultural nuances, such as the male character grieving his inability to return home and the female character grappling with family conflicts. Collectivist values were highlighted, with the male case valuing community respect and seeking advice from an elder brother. Physical symptom management strategies emphasised family visits over interactions with friends, and graded exposure tasks included local Arab community engagements, acknowledging the perceived loss of social status. Relapse prevention plans were also customised to address gender-specific risk factors and family dynamics.

Systematically altering an evidence-based treatment protocol to consider and accommodate culture, language and context, helps to ensure that it is compatible with the individual's cultural meaning, values and patterns (Bernal, Jiménez-Chafey, Domenech-Rodríguez, 2009). From a phenomenological perspective, a pure CBT approach would dismiss the "first-person" perspective, and not explore the meanings an individual attach to experiences of psychological difficulties (Gallagher & Zahavi, 2020). Such explorations are crucial, as language in therapy is defined as the primary vehicle of communication, allowing clients to share their history, and experiences and express their emotions and personal identity formation (Bonn, 2015; Brown & Altarriba, 2018). Thus, adjustment to CBT is required for it to be acceptable, useful and accessible for non-western cultures, as highlighted by studies conducted in the UK, Pakistan and China (Al-ghatani et al., 2019; Bernal et al., 1995; Hays & Iwamasa, 2006; Naeem et al., 2010).

The cultural adaptation of CBT needs to consider the following: religious and cultural factors as well as beliefs about health, disorder and treatment, spiritual factors, method of delivery and structure of the intervention (Naeem et al., 2015). Also, it is important to recognise that culture can significantly influence treatment-seeking motivations among ethnic minority individuals, and the importance of considering this when treating clients has been well established (Perera et al., 2020). Cabbas & Bouman (2013) note that cultural adaptations can reduce treatment continuation, distrust in MH care, and unintended harmful practices.

Despite its documented importance, there is a dearth of research reporting on culturally adapted psychological interventions that meet individual needs (Bernal & Sáez-Santiago, 2022). From existing research, the following are identified considerations in the cultural adaptations of interventions, language and communication, concept of illness model, family, context and method of delivery, therapeutic alliance, and treatment goal and engagement. Each will be described in turn.

2.5.1 Language and communication

Cross-cultural researchers have often reported language to be an issue across various therapeutic models, including CBT (Hanely, 2014; Lee et al., 2014; Mental health foundation, 2019). This means that the terms commonly used in CBT tools may need to be exchanged with culturally appropriate words to improve cultural acceptability and relevance (Naeem et al., 2015, So et al., 2015). For instance, the same word is used to describe 'shy' and 'embarrassment' in the Kurdish language, which can lead to lost or confused emotions in translation. Among non-western individuals, emphasis may be placed on non-verbal and indirect communication, which could be due to associating MH to physical health problems and, as a result influence treatment-seeking behaviour. By contrast, European/American individuals tend to value self-disclosure during interaction with the therapist (Hall & Eap, 2007; Leong & Lee, 2006). Individuals from non-western cultures can also be more obedient to authority figures and may struggle with expressing disagreement with a therapist (Kim, 2015). Therefore, paying attention to non-verbal communication is vital, as disagreement can be shown through late arrival to therapy or non-attendance (Naeem et al., 2019).

Hays (2019) reports that in many cases where a client comes from a minority group, the therapist of the dominant cultural identity might not recognise cultural influence due to not having experience working with minority groups or with a culture which may contrast with their culture. The dominance of a European American (EA) perspective in the assumptions of CBT is not solely due to the disproportionate number of EA providers, it is also linked with reinforcing dominant cultural norms and perceptions by the bigger society to which psychotherapy belongs (Degnan, 2017). To exemplify, the therapeutic and social emphasis placed on the EA values of 1) assertiveness during social interaction over subtlety, 2) change over perseverance, patience and acceptance, 3) individual independence over interdependence, and 4) self-disclosure over the protection of the family reputation.

Teaching methods such as encouraging collusion and active sharing among passive cultures and using practical rehearsals and visual aids have been used in some research to try and account for this (Chien & Lee, 2010). Using stories to convey a message has been reported to be effective alongside pictures in handouts (Naeem et al., 2013; Naeem et al., 2019), as well as the use of religious coping methods and practises (Degnan et al., 2017).

2.5.2 Concept of illness model

Culture influences the expression and recognition of mental health symptoms, including those related to emotional eating. Middle Eastern cultures may interpret mental health concerns, including emotional eating, through a predominantly somatic lens rather than a psychiatric one (Gopalkrishnan, 2018; Melissa et al., 2020). This is because in many cultures, the mind and body are viewed as one. This emphasis on biological factors may result in individuals explaining their distress somatically, reporting symptoms such as nausea or stomach-ache when referring to or describing anxiety (Melissa et al., 2020). This cultural tendency to interpret emotional distress somatically could have implications for the recognition of behaviours associated with emotional eating. The failure to recognise EE symptoms within a psychiatric framework may lead to delayed help-seeking behaviours and greater severity of symptoms (Gopalkrishan, 2018). If EE is predominantly expressed or perceived in somatic terms within a cultural context, individuals might not readily associate their behaviours with mental health issues.

In view of these findings, when exploring EE in diverse cultural contexts it is imperative that counselling practitioners consider how cultural interpretations may influence the perception and acknowledgment of symptoms. For example, in Islamic thought, the physical realm is interconnected with the broader human psyche. Ghazali's insights (1986) reinforce the notion that addressing spiritual aspects of the heart necessitates attending to the

well-being of the physical body (Kemahli, 2017). Awareness of such cultural nuances is vital for designing effective psycho-educational interventions that can bridge the gap between somatic expressions and psychiatric understanding, facilitating early recognition, and timely help-seeking behaviours (Melissa et al, 2020: Mond, 2014).

2.5.3 Family

Considering the intricate interplay between familial roles, emotional eating, and psychological well-being is crucial in developing effective interventions. In Middle Eastern cultures, traditional gender roles assign wives the primary responsibility for domestic work and child-rearing, while husbands are expected to provide financial support (Hassan et al., 2010). This division of labour can pose challenges, especially for Middle Eastern women, as the transition into marriage may exacerbate domestic workloads, potentially impacting their emotional well-being (Assaad et al., 2017).

When designing psychological interventions, it is essential to recognise and integrate the significance of family dynamics. Family-oriented interventions can offer a holistic approach by involving spouses and other family members. In doing so, these interventions acknowledge the cultural context, ensuring that emotional eating patterns are addressed within the broader familial and societal framework. Inclusivity of family members fosters a supportive environment and may enhance the effectiveness of interventions, considering the cultural values and expectations associated with family role.

2.5.4 Context and method of delivery

When engaging with non-Westernized individuals, consideration of context and location in the delivery of psychological interventions can determine intervention efficacy and participant engagement. Research indicates that limited transportation options significantly contribute to dropout rates when delivering interventions (Gater et al., 2010; Kaltman et al.,

2016). This finding was echoed by a systematic review on the effectiveness of adapted psychological interventions for people from ethnic minority groups, where it was reported that 22% of studies made changes to the location of intervention delivery, ranging from delivering interventions in individuals' homes to community or non-healthcare settings (Arundell et al., 2021). The selection of an easily accessible location can help ensure active participation from non-Westernized individuals by mitigating logistical challenges (Leiler et al., 2020; Ryan et al., 2018; Scogin et al., 2007).

Allowing flexibility in the organisation of sessions has also been found to improve intervention effectiveness (Khan et al., 2019; Reay et al., 2006). For example, interventions delivered during the school term have been found to attract more women and reduce dropout rates among non-Westernized individuals, as it harmonises with the cyclical patterns inherent in individuals' lives (Assaad et al., 2017). In their systematic review, Arundell et al. (2021) reported intentional adaptations reported by 23% of studies to the time or length of interventions. This included adjustments to the overall program length, individual session length, and the timing of intervention provision to increase cultural relevance and acceptability (Drozdek et al., 2012, Grote et al., 2009; Meffert et al., 2014). While established guidelines, exemplified by the National Institute for Health and Care Excellence (NICE, 2017) may prescribe a specific number of sessions over a defined period, the universal application of such recommendations is neither assured nor appropriate. Notably, preferences for brief psychological interventions have been discerned among non-Westernized individuals. This necessitates a departure from a rigid adherence to established guidelines, emphasising instead the imperative to tailor interventions to align with the cultural expectations and preferences prevailing within the target population.

2.5.5 Therapeutic alliance

Building a therapeutic relationship is essential. In a systematic review by Degnan et al. (2017) 28% of studies reported adaptation in order to enhance therapeutic relationships, including matching clients' and therapists' ethnicity and other characteristics such as gender, age and language. The importance of supervision and training to enhance cultural competence and knowledge has also been identified (Kopelowicz et al., 2012). Valencia et al. (2010) propose that appropriate forms of self-disclosure (therapists) can be helpful to facilitate a better personalised therapeutic alliance. Although self-disclosure may not be supported by some modalities such as psychotherapy, Freud (1964) proposes that in a client-therapist relationship, it is the client who discloses (Phiri et al., 2019).

Due to the beliefs of individuals from BME ethnicity about sharing personal problems with an outsider of the family, they can be more reluctant to disclose within a therapeutic environment, which can impact treatment outcomes (Phiri et al., 2019; Tanhan & Young, 2022). Phiri et al. (2019) reported that therapist self-disclosure can be of significance for some BME clients who assess therapist through their use of self-disclosure as well as their responses to the client. This means that self-disclosure can be a purposeful voice or bridge to demonstrate understanding of a client's state at that moment, engage the client in therapy and reciprocal a therapeutic relationship. Therefore, one of the ways to help individuals from BME backgrounds to disclose is through therapist disclosure.

2.5.6 Treatment goal and engagement

In setting a treatment goal when working with individuals from non-western cultures, developing a shared goal to meet the needs of the individual and family is considered important (Hall et al., 2019). This may reduce drop-out rates which is typically found to be high among individuals from non-western cultures (Rathod & Kingdon, 2014). However, a further possible explanation for drop-out, are expectations about psychotherapy outcomes, namely, the need for gaining meaningful benefits early in treatment, which are more

prevalent in minority cultures (Jane & Pistrange, 2007). Naeem (2019) stated that the first few sessions are significant as patients may expect immediate reliefs, with a focus on symptom management recommended at the beginning which may increase engagement with and confidence in the therapist. Finally, some therapy modalities include homework, which can be beneficial; however, completing homework tasks has been reported to be problematic for western cultures and even more for non-western cultures due to lack of engagement in completing homework. Williams et al. (2016) found that individuals from non-western cultures may be less likely to engage in tasks outside of treatment due to fear of performing poorly (Williams et al., 2016).

2.6 Summary

This literature review highlights biological, psychological, and psychosocial factors that can lead to EE (Bruch, 1964; Spoor et al., 2007; Leersnyder et al., 2015; Siren & Sanlier, 2018). Specifically, among Middle Eastern cultures, there are also various factors which may explain attitudes towards sharing or expressing unpleasant emotions, including cultural and religious barriers such as the need to maintain a high family reputation and respect, limited knowledge of MH, stigma linked to MH and seeking help and gender role expectations. As a result of MH stigma and other beliefs, individuals from Middle Eastern cultures supress unpleasant emotions and may seek comfort in overeating (Dardas & Simmons, 2015; Krstanoska-Blazeska et al., 2021; Zolezzi et al., 2018).

Research among non-western individuals who have moved to another country reports a desire to preserve their culture through food practices whilst living away from their country of origin, and to pass this on to their children. This also highlights the influence of acculturation on individuals, which has been linked to stress, anxiety and depression due to the demand of getting used to another culture, and lack of support from family and friends

(De Oliveira et al., 2017). Studies have shown that Middle Eastern women tend to overeat to seek comfort as a substitute for this lack of support (Doumit et al., 2016; Wilson & Tyler, 2018), and seldom seeking professional support due to cultural stigma regarding emotional difficulties and weakness (MHF, 2018). They are more likely to seek support from religious and faith healers (Dardas & Simmons, 2015; Kingdon, Phiri & Gobbi, 2010; Krstanoska-Blazeska et al., 2021).

The mental health foundation (2018) has highlighted the need for culturally sensitive interventions to move beyond the one-size-fits-all rationale (Purgatory et al., 2021). This is due to predominantly western models and may not apply to non-western individuals (Wang, 2017). Culturally adapted intervention has reported significantly better treatment outcomes including higher satisfaction and engagement (Meyer & Zane, 2013; Rathod, 2010), compared to non-adapted interventions (Smith, Rodríguez, & Bernal, 2011). However, there is a gap in the literature when exploring EE among individuals from Middle Eastern countries, with most research undertaken with western, Chinese, or Pakistani/Indian populations.

This programme of research seeks to address this gap by seeking to better understand EE among Middle Eastern women, thereafter, engaging this population to help develop and deliver a culturally adapted intervention for use with Middle Eastern living in the UK. Specifically, this will seek to consider language, culture, and context compatible with the individual's cultural beliefs, values and patterns. According to Bernal and Adames (2017), this is an ethical responsibility of health care professionals to prevent harm.

CHAPTER THREE: Methodological Considerations for this Programme of Research

This chapter will first discuss ontological and epistemological considerations relative to the undertaking of this programme of research. This is followed by reflexivity regarding the researcher's personal experience of utilising personal therapy and supervision relevant to the aims of this work**.**

3.1 Ontology and Epistemology

Ontology was carefully considered when designing the current research program. Ontology deals with 'the study of being'—exploring the nature of existence, the structure of reality, and their interplay (Crotty, 2003). Bracken (2010) suggests that acknowledging ontological aspects can help researchers discern the impact of philosophical, historical, and cultural contexts on knowledge claims. This research aligns with counselling psychology's view that emphasises pluralism, recognising the coexistence of multiple truths (Cooper & McLeod, 2011). Willing (2019) underscores the importance of acknowledging simultaneous existence of multiple truths, citing two key reasons.

Firstly, when the client differs from the therapist's assumptions, effective therapeutic progress becomes compromised. Secondly, lacking this awareness raises the ethical concern of inadvertently imposing the therapist's perspective on the client. This underscores the significance of embracing cultural differences in experiencing and managing EE. Aligning with this research program and researchers' ontological stance, Brown (2021) asserts that research conducted for the benefit of people should inherently mirror their experiences.

Epistemology concerns the "way of understanding and describing how we know what we know" (Crotty, 2003, p. 3). As a counselling psychologist (trainee), and within this research programme, knowledge acquisition is guided by a constructivist epistemological stance. Maxwell (2011) defines constructivism as "the position that our understanding of

reality is a social construction, not an objective truth, and that there exist 'multiple realities' associated with different groups and perspectives".

Furthermore, constructivism holds that the individual is proactive in constructing their truth and that knowledge consists of a meaning-making process where the individual oversees their experience (Lee et al., 2018). In other words, reality is not stable, single, or external; and an individual's emotions and behaviour cannot be meaningfully distinct from human thoughts (Lee et al., 2018). In my counselling practice as a constructivist therapist, I work in an individualistic, reflective, and collaborative way. As a researcher, a constructivist approach similarly considers an individuals' uniqueness and diversity. Following a constructivist approach in undertaking the present research programme, I will encourage in-depth reflections among participants to explore the meanings behind Middle Eastern women's narratives of EE and its management (Muellenbach, 2015).

As a counselling psychologist conducting research in cross-cultural therapy, my decision to align with constructivism over social constructivism is grounded in several intertwined considerations. First, constructivism's emphasis on individual cognitive processes and knowledge construction resonates more closely with the positivist traditions that often underlie Western psychology and cross-cultural therapy (Navarro, 2013). While social constructivism offers valuable insights into collective meaning-making and societal discourses (Philips, 2023), I found that constructivism provides a more nuanced framework for understanding how individual cognitive processes intersect with broader socio-cultural contexts in therapy.

Second, the complex nature of cross-cultural therapy necessitates a nuanced understanding of the historical and economic factors that shape both therapists and clients (Sue et al., 2009). As highlighted by Lago and Thompson (2003), these factors, often manifested as social structures, significantly influence therapeutic interactions. While social

constructivism emphasises the relational and contextual dimensions of knowledge, constructivism offers a more comprehensive lens for examining how individual cognitive processes interact with these broader socio-cultural dynamics (Philips, 2023). From a practical perspective, the focus on individual cognitive processes in constructivism aligns with the call for culturally appropriate supervision and training in cross-cultural therapy (Lago & Thompson, 2003). By emphasising the role of individual experiences and cognitive processes, constructivism offers valuable insights into the dynamics of cross-cultural interactions, thereby enhancing the effectiveness of therapeutic interventions.

Finally, reflexivity, a pivotal aspect of qualitative research, encapsulates both constructivist and constructionist dimensions, as articulated by Guba and Lincoln (2003). In my research, I found that constructivism provided a more robust framework for critically examining my role and positionality, especially given my ethnic background. Reflexivity was instrumental in navigating the intricacies of cross-cultural therapeutic encounters and ensuring that the research remained sensitive to the complexities of individual experiences.

In summary, my choice of constructivism over social constructivism in cross-cultural therapy research reflects a deliberate alignment with theoretical frameworks that prioritise individual cognitive processes whilst acknowledging the broader socio-cultural contexts that shape them. This approach, I believe, offers a nuanced and comprehensive understanding of the complexities inherent in cross-cultural therapeutic encounters.

3.2 Reflexivity, Personal Therapy and Supervision

Reflexivity in research involves acknowledging the potential influence of the researcher on both the research subject and participants, recognising the reciprocal influence of the research experience on the researcher (Gilgun, 2008). This requires maintaining a continuous, iterative connection between the researcher's responses and the intersubjective dynamics of the

research process (Probst, 2015). Probst and Berenson (2014) note that a self-awareness of bias evolves through internal introspection and external actions, both aspects integral to reflexivity. This sub-section outlines the researcher's personal and professional background, addressing their role in the research process and knowledge development (Cohen & Crabtree, 2006).

As a female of Iraqi origin with Dutch nationality, having lived, studied, and trained in Kurdistan (North Iraq), the Netherlands, and the UK, I have a knowledge of languages and socio-cultural considerations pertinent to the focal population (Arabic women) in this research. During my doctoral training, engaging in activities to raise mental health awareness among Arabic, Iranian, and Somalian communities has deepened my insights, particularly in understanding unique challenges faced, such as stigma, service awareness gaps, discrimination, language barriers, and professional knowledge deficits. This exposure has made me more aware of concerns within BAME communities, partly attributed to culturally insensitive interventions and the application of Western-centric psychotherapy models (Khan, 2017; mental health statistics, 2014).

The training I have undertaken in completing my doctoral studies has increased my confidence in integrating approaches to ensure culturally sensitive therapy. Working with a minority group, particularly women, directed me toward my thesis focus: investigating the relationship between Middle Eastern women and food and crafting a culturally adapted intervention to manage emotional eating. Drawing from my contextualised knowledge, I formulated interview questions aligned with an ethnographic approach, seeking a deeper understanding of the participant population (Suzuki et al., 2014). Reflecting on the intersection of culture and professional practice, I recognised the complexities inherent in cross-cultural interactions. This prompted me to continually reflect on the delicate balance

between cultural norms and professional boundaries during the intervention, acknowledging the importance of maintaining integrity while respecting cultural perspectives.

To address potential biases, I remain vigilant and engage in continuous reflexivity throughout the research process. Reflecting on my positionality, biases, and interactions enables me to navigate potential influences, maintain objectivity, and ensure a participant-centred approach. Seeking peer debriefing, utilising reflexivity journals, and engaging in critical dialogue with my supervisory team, participants and colleagues further support the identification and mitigation of biases, fostering rigor, authenticity, and ethical integrity in the research.

Engaging with personal therapy, clinical supervision, journal writing, and attending personal and professional development sessions have enabled me to engage with self-assessment. I have explored my emotional reactions, thoughts, cultural position, and assumptions across various contexts during this process. This reflexivity is of great value due to focal population for this research. As participants were Middle Eastern women, I must acknowledge and reflect upon my own beliefs, values, and behaviours as a fellow Middle Eastern woman to avoid making assumptions about what participants may mean which is fundamental to the practice of counselling psychologists to increase personal growth. Schon (1983) reports that reflective practice involves more than rational, academic, and technical knowledge. Lavender (2003) contributes to this idea by adding the importance of two other processes: self-reflection and reflection on the impact on others. This became a goal for me to explore in therapy as I continue adhering to the code of conduct and Ethical standards of the Health Care and Professional Council (2021) and the British Psychological Society (2018). Through this reflective journey, I have learned the importance of shifting my thoughts from viewing vulnerability as a weakness to seeing vulnerability as having courage.

Brene Brown (2021), an inspirational figure for me, stated, "*Vulnerability is the birthplace of love, belonging, joy, courage, empathy, and creativity*. *It is the source of hope, empathy, accountability, and authenticity"* (p. 120). This quote builds on the contentions of Van Boven et al. (2012, p. 53), who contend that vulnerability requires courage. Reading published literature such as this encouraged me to embrace and view vulnerability differently. It inspired me to be compassionate towards myself and expressive about my struggles. My supervisors often reminded me about my passion for helping minority groups and the rationale for this programme of research. I learned to appreciate talking about emotions, feeling vulnerable, and seeking help which is the opposite of what I have been brought up with as a Middle Eastern woman. This has further enhanced my understanding of the issues and barriers Middle Eastern women face resulting from cultural beliefs, whilst also remembering to stay within their frame of reference throughout to maintain this study's rigour.

My epistemological stance and constructivist approach position participants as experts in their own lives, fostering openness, flexibility, and proximity to participants' experiences during data collection and analysis. Sharing data interpretations with diverse supervisors further fortifies rigor, providing diverse perspectives and allowing for reflection and refinement to ensure plausibility.

3.3 Research Design

3.3.1 Sequential Mixed Method Design

This research programme adopted a sequential mixed method design starting with an exploratory qualitative phase followed sequentially by a mixed methods pilot study (Sage, 2019). This mixed method design (MM) enabled EE to be explored in depth by first considering cultural factors influencing EE, and thereafter developing and piloting a

culturally adapted intervention to help female Middle Eastern participants manage their EE (Cresswell et al., 2007). Mixed method designs are flexible, and capitalise on findings reflective of lived experiences, thus ensuring that the results are considered from an individual's perspective (Renault et al., 2018). Mixed methods designs have been used widely within healthcare settings. For example, Harrison et al. (2016) utilised MM to aid with the development of CBT or ACT self-guided interventions with positive results (Harrison et al., 2016). Otslund et al. (2016) argue that MM can be perceived as an approach which draws upon the strengths and perspectives of each method, acknowledging the importance and existence of the natural and physical world along with the importance of realism and the impact of this on human experiences (Ostlund et al., 2016).

Cresswell (2009) proposes that using MM can sometimes be in tension, but such as tensions is good. For example, despite the researcher's constructivist position, a quantitative approach has been integrated into phase 2. Shannon-baker (2015) suggests the researcher's focus should be on enhancing transferability based on the trustworthiness and reliability of the qualitative approach and the strength of the link between causes and effects in quantitative data (Shannon-Baker, 2015). In other words, MM can highlight the differences and similarities between particular aspects of the phenomenon under investigation, in this case, EE. This means that MM can offer an in-depth understanding of the association between empirical and theoretical findings, thus challenging existing assumptions and developing or adapting new theories (Ostlund et al., 2016). In this study, phase one used a qualitative approach to gather an in-depth insight into the experiences of Middle Eastern women with EE, along with their intervention needs; these findings led to the development of the culturally adapted intervention. The effectiveness of the intervention was measured utilising a quantitative approach (measures of emotional eating, and perceptions regarding intervention ease of use and efficacy) using the EE subscale from the modified Dutch Eating

Behaviour Questionnaire (DEBQ: Bailly et al., 2012). It is worth noting that while the DEBQ's primary validation was with a Dutch population, researchers have undertaken research to assess its validity and reliability in different populations, for example, UK (Dewberry & Ussher, 1994; Lopez & Johnson, 2016), Germany (Nagi et al., 2016), Spain (Cebolla et al., 2016), Brazil (Moreira et al., 2017), Italy (Caccialanza et al., 2004), Romania (Arhire et al., 2021), Maltese (Dutton & Dovey et al, 2016), and Lebanon (Ghadieh et al., 2020). A qualitative approach was also utilised to allow the participants to share their experiences with the intervention and, thus gain more insight into the scores obtained through the quantitative approach.

3.3.2 Mixed methods techniques utilised in this programme of research

In terms of techniques, research suggests that the purpose of MM should be clear to ensure analysis techniques are related to one another, or to consider how the results can be integrated (Tashakkori & Creswell, 2007). Ostlund et al. (2016) argue that the characteristics of a truly MM research involve the integration of results from the qualitative and quantitative approach. There are several ways to do this; 1) contemporary data analysis approach (where data is integrated during the analysis stage), 2) parallel data analysis (data collection and analysis for both methods are conducted separately, and the findings are compared at the interpretative stage), and 3) the sequential data analysis (SDA) (Figure 3). SDA was utilised in the present research, which involves data analysis in a particular sequence intending to inform rather than being integrated with the results from the other method. Specifically, in this study, qualitative data analysis of in-depth interviews from the first study led to the development of a culturally adapted intervention in the second phase of the study. Using interviews enabled an in depth understanding of EE among Middle Eastern women, and cultural considerations in developing a subsequent intervention.

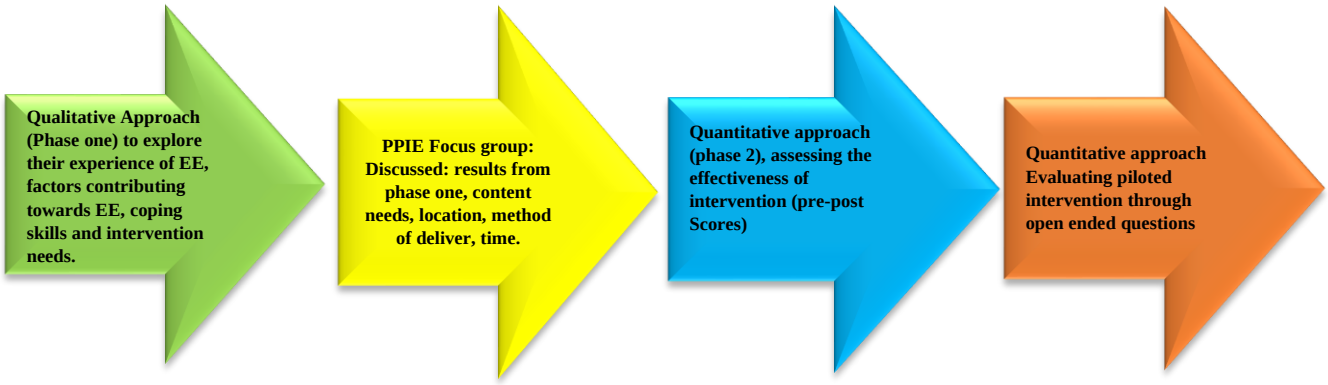

Figure 3: Sequential data analysis of this research

The involvement of the target population in developing an intervention is highly recommended to attain improved outcomes, by identifying an individuals' priorities and needs (Regnault et al., 2018). Kirwan et al. (2017) note that including participant voices in mixed methods research improves outcomes that can be shared with other key stakeholders (Kirwan et al., 2017). Furthermore, encouraging participant engagement throughout the mixed methods approaches potentially offsets the shortcoming of a single method and produces more reliable findings (Hafsa, 2019). In this study, Patient and Public Involvement and Engagement (PPIE) was employed, which has been shown to have many benefits, including allowing the participants to have a voice in the development of the intervention and helping the researchers to understand the lived experiences of the patient and public in particularly when including seldom-heard communities (Teodorowski et al., 2023).

Through PPIE the findings obtained during phase one were shared with Middle Eastern women; inviting them to reflect on the findings. They were also asked to share their own experiences as Middle Eastern women who wished to better manage EE, and in doing so, identify those needs that they would like to see accommodated in developing a culturally adapted EE intervention. This included preferred intervention type (e.g., CBT or mindfulness), method of delivery (e.g., online or face-to-face), location, time, structure, and number of sessions.

CHAPTER FOUR: Phase One Methods

4.1 Participants

Twenty participants initially expressed interest in participating in the study. Ten expressions of interest were received as a result of Facebook and community centre advertisements, and an additional ten were recruited via snowball sampling (Browne, 2005). With the primary objective of investigating emotional eating, the study is focused on EE within the context of Middle Eastern women, explicitly avoiding an examination of eating disorders (ED). The research employed a robust screening process, informed by the researchers' clinical expertise derived from two years of working within an eating disorder service. In this clinical setting, daily assessments, including the use of the Eating Disorder Questionnaire (EDQ), are standard practice to identify and assess individuals for potential eating disorders. As such, the researcher was able to utilise skills obtained in assessing and identifying the difference between EE and ED. Out of the screened participants, 16 met the predefined inclusion criteria (refer to Table 1). Three individuals were excluded due to meeting the criteria for binge eating disorder, prompting the provision of appropriate support referrals to address their specific needs. A further participant who faced challenges expressing thoughts in the English language voluntarily withdrew from the study.

Sample size in qualitative research lacks a fixed criterion. Charmaz (2006) advises data collection to cease upon reaching data saturation, when new theoretical insights cease. Braun and Clark (2021, p. 215), however, question the utility and coherence of data saturation. Alternatively, Malterud et al. (2016) propose "information power" as a more relevant determinant. This concept posits that a sample rich in study-relevant details requires fewer participants. Information power hinges on 1) research objectives, 2) sample specificity, 3) established theory use, 4) dialogue quality, and 5) analysis method (Malterud et al., 2016).

Malterud et al. (2016) advocate fewer participants for highly specific studies compared to broader ones. Yet, limited EE research among Middle Eastern women led to surpassing the typical 6-10 participant range in qualitative research (Padgett, 2012). A decision to stop recruitment at 16 participants was informed by the strength of dialogue between the researcher and participants.

Several factors contributed towards a strong dialogue, such as the researcher having prior experience in conducting interviews, the researcher originating from a Middle Eastern country meaning that she was able to understand, help and challenge the participants when required, and the positioning of participants as the expert in conveying their experiences.

Table 1: Participant demographics

Name	Age	Ethnicity	Occupation & marital status	Number of children
Lara	36	Kurdish	Social worker /Engaged	One
Zizi	42	Saudi Arabia	Housewife/Married	Three
Shan	37	Iraq	Support husbands' business /Married	Two
Betul	34	Turkey	Housewife/Married	Two
Maha	40	Iran	Housewife/Married	One
Sale	39	Iran	Housewife/Married	Three
Suzie	43	Lebanon	Accountant (part-time)/Married	Two
Deman	36	Afghanistan/Lebanon	Social worker/Divorced	Three
Rula	42	Egypt	Housewife/Married	Three
Mina	42	Kurdish	Housewife/Married	Three
Lina	40	Yemen	Housewife/Married	Three
Aiman	40	Syria	Student/Divorced	Two
Samira	36	Iraq	Housewife/Married	Three
Cey	40	Turkey	Neurologist/Married	Two

Aryan	28	Palestine	Student/Single	None
Noah	32	Jordan	Optometrist (not working)	None

4.3 Interviews

The semi-structured interview was designed based on EE literature and relevant EE measures, such as the EE questionnaire (Garaulet, 2012). To suit Middle Eastern populations and comprehend culture's impact on beliefs and behaviours, ethnographic interviewing techniques were applied (Deal, 1985). This approach addressed three key experience facets when framing questions: cultural language (expression of their world and knowledge), cultural behaviour (actions undertaken), and cultural artifacts (items used or created) (Suzuki, 2021).

In developing interview questions, acknowledging my insider status as a Middle Eastern female was crucial, as it could shape the questions posed. To mitigate the impact of being too familiar, maintaining an open-eyed and curious stance was essential for insider researchers (Fleming, 2018; Rahem et al., 2016). While being an insider aids interviewing, analysis, and interpretation due to familiarity with the case's intricacies (Fleming, 2018, p. 318). Fleming also notes: “An outsider researcher is potentially at risk of not noticing interesting data because of a lack of understanding of the specific context that the comments are related to”.

In order to account for these considerations, and to check the suitability of questions asked in terms of ease of understanding for participants, and perceived relevance, two pilot interviews were completed. On both occasions pilot participants were asked to provide critical feedback on the interview schedule and design. This led to a revised interview schedule, by reducing the number of questions asked and simplifying the language used. For instance, the term “intervention” was modified to “program” as this was deemed more familiar and understandable.

4.4 Procedure

Ethical approval (approval code 0822SAUOWPSY) was obtained from the University of Wolverhampton ethics committee prior to data collection (see appendices A & I). Participants were recruited through recruitment posters shared on Facebook, Twitter groups, and community centre notice boards frequented by Middle Eastern women. Consent was obtained from relevant Facebook administrators and community group leaders. The recruitment posts indicated the study's focus on "exploring the relationship between your emotions and you're eating habits." These posters detailed the study's purpose, participant tasks, and inclusion/exclusion criteria.

Inclusion and exclusion criteria stipulated participants to be aged 18 or older and proficient in English. Those with suspected or diagnosed eating disorders were excluded due to differing treatment requirements (Reichenberger et al., 2021). Additionally, participants needed to perceive EE as an area they wished to improve in order to be included.

Interested individuals received an information sheet and consent form via email (see appendix B & C), detailing participation expectations and offering the chance to seek clarification. Signed consent forms were electronically returned before the scheduled interview. Prior to the interview, the study's objectives were reiterated, and a final screening against criteria occurred. Upon confirming eligibility, verbal consent was reaffirmed, granting participants the option to withhold answers or halt the interview at any point.

Participants (n = 16) were interviewed remotely via Zoom (n = 3) or phone (n = 13) to adhere to COVID-19 distancing guidelines and ensure safety for all involved. This approach aimed to minimise potential risks. Participants were encouraged to select a comfortable, private location for the interview, with 12 opting for home-based interviews during school hours.

Post-interview, participants were offered the option to engage in the study's second phase involving a culturally adapted EE intervention. All 16 participants expressed continued interest in phase 2 participation. Following the interview, participants received an email containing an interview debrief form, which included mental health service information and the chance to request their interview transcript. This communication also reiterated the option to seek additional clarifications or withdraw consent (appendix B).

Interviews spanned 40 to 65 minutes each. Audio recordings were securely transferred to the university drive, with subsequent deletion from the recording device. Transcribed interviews were stored on the secure university hard drive for retention.

4.5 Data Analysis

Reflexive thematic analysis (RTA; Braun & Clarke, 2019) was used to guide data analysis. Braun and Clark (2019) encourage researchers to embrace subjectivity, creativity and reflexivity as positioned in knowledge construction to gain a depth interpretation of meaning rather than aiming to achieve a consensus of meaning. Furthermore, RTA encourages flexibility whilst identifying, analysing, and outlining patterns/themes within the data (Braun & Clark, 2012). RTA has previously been used effectively in research focused on EE and eating behaviour (Frayn et al., 2018; Wehling & Lusher, 2019), and to generate or evaluate behaviour change interventions (Palsola, 2020).

Analysis was guided by indictive and deductive reasoning. Inductive reasoning involves deriving general principles from specific observations, while deductive reasoning starts with general principles and examines specific instances to validate or refute them. An inductive approach was utilised in line with a constructivist approach and in seeking to ensure that the themes identified closely reflected the experiences and meaning of the participants (Greaves, 2014). Braun and Clark (2006) suggest that a solely inductive approach cannot be

followed as a researcher cannot free themselves of their biases including epistemological stance, and furthermore, this qualitative enquiry was guided by research questions. As such, a degree of deductive analysis was utilised to ensure that open coding supported the development of meaningful themes relevant to the research questions. For example, religious influence on help seeking and EE management is an example of deductive approach in this study. Previous research indicates that religious influence can present a barrier to seek professional help, which can consequently cause EE (Dardas & Simmons, 2015; Krstanoska-Blazeska et al., 2021; Zolezzi et al., 2018). As such the religious influence was deductively coded. Joffe (2012) purposes that great quality analysis adopts both the positions through holding one's preconceptions of the research while also keeping an open mind to new emerging ideas from the data.

The simultaneous use inductive and deductive approaches can be justified based on several methodological and theoretical considerations. First, from a methodological standpoint, combining inductive and deductive approaches can enhance the validity and reliability of the research findings (Bryman, 2016). Inductive reasoning allows for the exploration of emergent themes and patterns from the data, providing rich insights into the research phenomena. Conversely, deductive reasoning ensures that the research is grounded in established theories and literature, enabling the validation of the findings against existing knowledge. By employing both approaches, researchers can triangulate their findings, thereby enhancing the robustness of the research outcomes (Yin, 2018).

Secondly, the integration of inductive and deductive approaches can facilitate a dynamic interplay between theory and data, fostering iterative and reflexive analysis (Charmaz, 2014). This iterative process allows researchers to refine their conceptual frameworks in response to the evolving data, thereby enriching the theoretical insights generated from the research (Miles, Huberman, & Saldaña, 2014). The integration of both

inductive and deductive approaches has been extensively utilised in previous research. For example, Melia et al. (2021) used both approaches to better understand the lived experiences of mental health professionals who adopt mobile health technology. Similarly, Berzins et al. (2020) utilised inductive and deductive approaches to understand mental health service user and carer viewpoints on safety issues in UK mental health services.

In summary, the simultaneous use of inductive and deductive approaches in research offers a methodologically rigorous and theoretically robust framework for exploring complex research phenomena. By integrating these contrasting approaches, researchers can navigate the complexities of the research process more effectively, thereby enhancing the validity, reliability, and depth of the research findings.

The six step-by-step guides developed by Braun and Clark (2006, 2019) was used to facilitate analysis of the data. Braun and Clarke (2020) state that it is important to appreciate the six steps as a guideline rather than a regulation due to the likelihood of new interpretations emerging as the researcher navigates through the stages. As such the six steps should be employed flexibly to fit the data and the research question. How the steps were undertaken during the analysis of data for this study was as follows.

First, data familiarisation was attained through transcribing the interviews, reading and re-reading the entire dataset whilst highlighting passages and making notes alongside these to aid with data interpretation (Appendix G, step 1). This enabled a deep immersion into the dataset and identifying information relevant to the research question (Braun & Clark, 2013). During the second step, coding was undertaken line by line using NVivo 12 to retrieve and organise the data into meaningful groups for each interview transcript (Appendix G, step 2). During the third stage, codes were reviewed and analysed to examine the relationship between codes. This often involved collapsing codes with similar meanings into one code (e.g., cultural expectations and cultural influence) and codes could also be developed as a

theme or sub-theme during this stage (Braun & Clarke, 2012). This meant that the focus changed from interpreting participant's data to interpreting accumulated meaning and meaningfulness transversely across the data. Braun and Clark (2013) highlight the importance of code patterns communicating something eloquent to aid with answering the research questions rather than the number of codes informing a theme (see appendix G, step 3).

During the fourth stage, themes were thoroughly reviewed with alterations as deemed appropriate, for example by adding a sub-theme to clarify and facilitate the most meaningful interpretation of the participant's experience. In an illustration of this, the theme: self-help to regulate EE was altered following review giving more insight into participants experiences with the addition of three subthemes: 1) Coping with unpleasant emotions, 2) Compensatory behaviour, and 3) Seeking professional help (Braun & Clarke, 2020). Stage five focused on defining and naming themes to determine the narrative of each theme relative to the research questions. During this process, illustrative transcript extracts were identified to produce an analytical report. This required the participant's extracts to be contextualised relative to existing literature when writing up the results, which is acceptable in the write-up of RTA (Braun & Clark, 2013).

Finally, the theme names were reviewed to ensure they were informative, concise, and memorable (Braun & Clarke, 2020). The final phase involved producing the final write up as presented in this thesis. Braun and Clarke (2020) note that where possible, themes should build upon earlier stated themes whilst also being able to communicate individual stories if isolated from the rest of the themes.

4.6 Critical Friends

The use of "critical friends" refers to the critical interchange among researchers intended to support reflexivity through challenging each other's construction of comprehension of data

(Cowan & Taylor, 2016). In this instance, supervisors who listened to the interpretations of the researcher and provided critical feedback (Smith & McGannon, 2017). Critical friends can act as supporters, facilitators, challenges, or advice, depending on the context. The benefit of critical friends includes being provided with an alternative perspective, protection from bias, self-delusion and support (Foulger, 2010). Research suggests that research can be more successful when using critical friends as advisors (Foulger, 2010; Noor & Shafe, 2021). Throughout each stage of RTA, regular meetings with my supervisors were held to reflect on and encourage exploration of alternative ways of exploring and interpreting the data and presenting and documenting a summary of the discussion and outcomes.

CHAPTER FIVE: Results and Discussion

5.1 Introduction

The study explored Middle Eastern women's perceptions and experiences of emotional eating, cultural influences on these experiences, and perceptions of existing EE interventions, along with recommendations for interventions tailored to their needs. Following reflexive thematic analysis (Braun & Clark, 2012), three themes were identified, ‘experiences of emotional eating’, ‘factors perceived as influencing emotional eating’, and ‘recommendations for culturally adapted EE interventions. Each theme was comprised of a number of associated sub-themes, which is a key focus of thematic analysis (Nowell et al., 2017). Each theme (and associated subthemes) will be presented in turn using illustrative quotes to highlight key points.

5.2 Theme 1: Experiences of Emotional Eating

Theme one presents participants' experiences of emotional eating, with three subthemes illustrating a cycle of EE, starting with ‘emotions perceived to be antecedents of EE’, ‘food choices during EE episodes’, and ‘consequences of EE’. Existing literature indicates that both pleasant and unpleasant emotions may lead to EE **(**Cardi et al., 2015), and so `emotions perceived to be antecedents of EE` (subtheme 1) were deductively coded as pleasant and unpleasant emotions. By contrast subthemes two (‘food choices during EE episodes’) and three (‘consequences of EE’) were produced using both inductive and deductive coding to ensure that cultural experiences were accounted for.

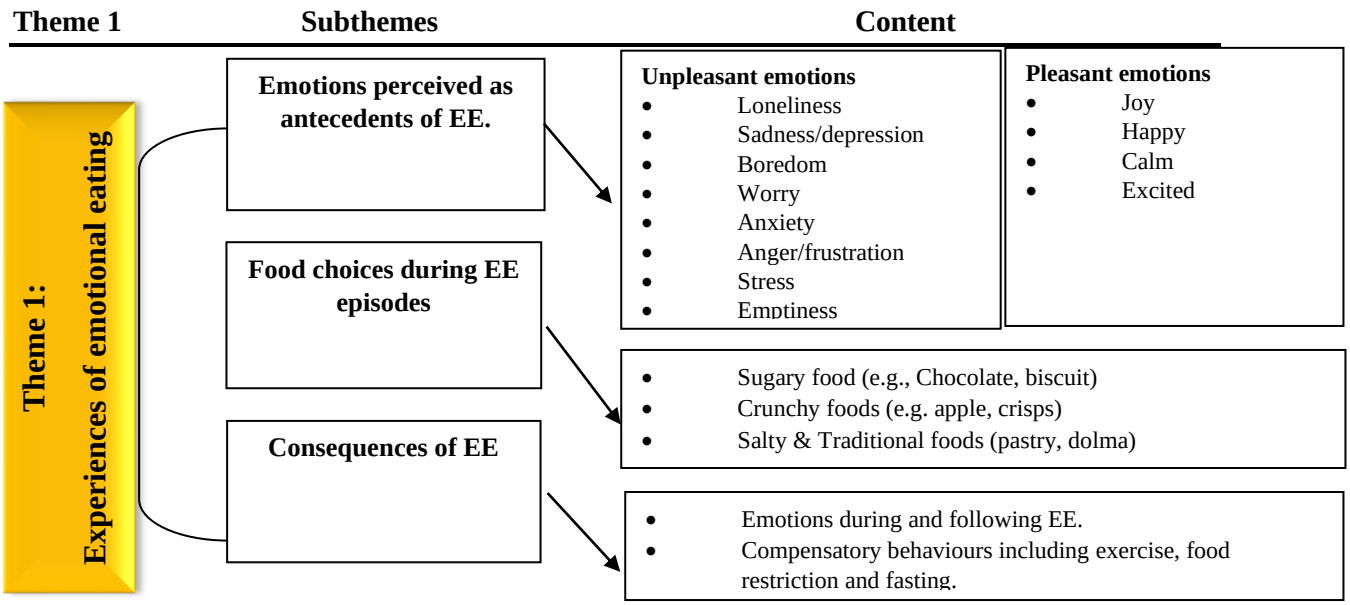

Figure 4: Experiences of Emotional Eating

5.2.1 *Emotions perceived to be antecedents of Emotional Eating*

All participants perceived their emotions as influencing their eating, as illustrated by Lara who noted: *"I do not think my eating is only because I am hungry…most of the time, it's because of how I feel"*. In line with previous research (Devonport et al., 2019; Evers et al., 2018), participants described a range of unpleasant, and to a lesser extent pleasant emotions they perceived as leading to EE episodes. Unpleasant emotions that could elicit EE included sadness (n = 16), boredom (n = 11), anger (n = 11), stress (n = 11), loneliness (n = 11), anxiety (n = 8), depression (n = 4), frustration (n = 3), worry (n = 3) and emptiness (n = 2). Previous research indicates that depression, anxiety, stress, anger, and other unpleasant emotions correlate with emotional overeating, including among Arabic populations (Fergus, Bardeen & Orcutt, 2012; Frayn et al., 2018; Strein, 2018; Konttinen et al., 2019; Péneau et al., 2013; Zeeni et al., 2013).

Using illustrative examples to explore the influence of unpleasant emotions on eating, participants described how they experienced sadness, stress, boredom, and/or loneliness during the Covid-19 pandemic. With participants worrying about themselves, immediate and external family members' health, and also experiencing uncertainty around when they would see family members again due to travel restrictions. Rula stated: "*Feeling worried about my family and about getting Covid, so you know, I started to eat, you know, I just feel this emotional, and this EE sorry, and I start to consume more* ". This finding supports previous research which indicates that EE can result from distress following a disaster (Bruce & Agras, 1992; Konttinen et al., 2021).

Boredom was commonly reported by participants as eliciting a desire to eat. Participant Maha noted, "*Boredom as well, that is another thing, because I feel, oh, I am so bored, I need something to nibble on, things like that*". Aiman noted: *"If I am bored, I eat a lot"*. Whilst previous research indicates that boredom can lead to EE, some researchers have argued that eating as a result of boredom should not be considered an unpleasant emotion, rather a separate emotional state (Koball et al., 2012; Crockett et al., 2015). Pleasant emotions perceived as increasing the urge to eat included happy, joy, calm, and excited (Athena, 2015; Micanti et al., 2016; Strein, 2018). Rula noted:

> *I just associate sweet with happiness… when I prepare my tea and my, my dessert, whatever I have, chocolate or cookie or whatever dessert that I make at home, I have them, in nice plates and I just take my book for instance. I just go to the garden, sit in a chair and just have it, and it gives me a feeling of peace and tranquillity and happiness.*

Similarly, Deman noted: "I *think when I am happy or calm, I eat more, like I have those you know, periods of me having just you know, happy days".*

Eating in response to emotions can occur due to numerous mechanisms, including a strategy to cope with unpleasant emotions, physiological fluctuations linked with emotions, or confusing emotional arousal with internal states of hunger (Quinones et al., 2018). Findings illustrate a range of emotions that may contribute towards EE episodes. This suggests that there may be benefit in educating individuals about coping strategies intended to manage the circumstances producing unpleasant emotions, and alternative means of emotion regulation other than the use of food (Herle et al., 2018).

5.2.2 Food choices during Emotional Eating episodes

The majority (n = 14) of participants described consuming sugary foods in response to unpleasant emotions. Betul described eating "*chocolate, and, and tea with biscuits, cookies, whatever I have, muffins, cakes"* whilst mina noted: "*think I'm addicted to sweets, and then I have to force myself to stop eating".* Epistemological reviews have indicated changes in food preferences in response to psychological difficulties: including consuming 'comfort foods' when experiencing unpleasant emotions (Firthy et al., 2020). The comfort foods consumed during EE tend to be foods high in fat or sugar or both (Koenders & Van Strein, 2011; Jacques et al., 2019). A possible explanation for this dominant food choice is the mood-regulation effects of sugar, as sugar consumption can work as a type of self-medication to manage everyday life stress (Brewerton, 2011; Fortuna, 2010; Polska & Esterowicz, 2016).

Participants described how the availability and accessibility food, along with the comparatively low price of unhealthy foods had influenced the choice of foods for EE moving to the UK. Lara stated:

> *Here in the UK shop you can see the complete difference of the pricing of different foods and different items, most of the foods that are unhealthy, sugary, they are really cheap, sometimes even a takeaway could be cheaper than doing a home cooked meal*.

Zizi noted:" *it makes it harder not to snack and here everything is in front of you, and shops, shops all around, and you can grab easily, you have it easy, that's why it might"*. Evers et al. (2010) state that EE is a strategy that individuals typically have easy access to manage unpleasant emotions. This is known as the toxic food environment, where unhealthy foods are readily available, technically safe to eat and more easily affordable (Wadden et al., 2002). However, it was also found that participants would often select typical Middle Eastern foods linked to their culture when acting on an urge to EE, such as rice, bread, crunchy food, nuts and traditional pastry foods (Stephenson & Ali, 2018). Maha noted: "*My culture, my traditional food is everything"* and Zizi noted: "*like a humous."* Lina reported: *"Actually I had different things, but mostly salty".* Zampini and Spence (2004) report that individuals' perception of pleasantness of foods can depend not just flavour in the mouth but also the sounds created when crunching on foods, and tangible sensations formed through the action of chewing. Participants offered some support for this when describing EE in response to certain emotions such as anger, frustration and sadness. Aiman noted:

> *I have a bowl of apples and whenever I'm angry I just grab the apple and start thinking you know, what am I going to do in this situation, and something I do a lot … yeah, just put my anger into the apple, not someone else.*

This further highlights the importance of cultural consideration in understanding the management of EE as well as food choices for individuals from different walks of life.

5.2.3 Consequences of Emotional Eating

This subtheme presents participants perceptions of the consequences of EE both during and following EE. Whilst one participant noted they were not consciously aware of EE happening, twelve participants reported feeling satisfied and experiencing enjoyment during EE. A finding which has been widely reported in previous research (Krstanoska-Blazeska,

Thomson, & Slewa-Younan, 2021). Aiman noted: *"I started eating, and enjoying myself really eating",* whilst Sahla stated: "*I'm happy, because I know I found a solution for my upset life*". Pleasant affective experiences such as those described can be linked to an increase of dopamine levels following consumption of sucrose (Van Strien et al., 1986), considered to be a highly palatable food. Zizi noted, *"I need a lot of sugary food to give me energy and relieve my stress, so emotional, yeah*". Aligned with theories of EE, this indicates that EE can have multiple functions including energy homeostasis, enjoyment, stress reduction, and distraction and relief from boredom (Schnepper et al., 2020; Ulrich-Lai et al., 2011; Ursano et al., 2009; Siren & Sanlier, 2018). Suggesting that comfort eating can provide a temporary distraction for individuals and thus provide short-term relief (Herle et al., 2018) Lina noted: *"I need to crush things when I eat, because I'm worried about something or I feel bad or depressed, yeah".* Indeed, EE can be helpful, however, long-term and excessive use of this coping mechanism can lead to unhealthy meal patterns, weight gain and other health complications (Brewer et al., 2018; Jacques et al., 2019: Whale et al., 2014).

Fifteen participants reported experiencing unpleasant emotions such as regret, guilt, disgust, and shame following EE which occurred either immediately or within one or two hours of EE. For instance, Aryan described "*just feeling really disgusted with myself, and just really ashamed",* Mina noted "*and after a while, I regret it",* whilst Aiman felt "*angry because, yeah, I feel guilty, it's more like a guilt, like because for example, I'm not very happy with myself".* Experiencing guilt following EE and overeating has been reported to be common (Donnelly et al., 2011), and according to Affect Phobia Theory (Egan & Fox (2017) future EE episodes may occur due to a negative feedback loop of the secondary emotions of shame or guilt towards the self-following EE. Consistent with previous research (Frayn, Livshits & Knauper, 2018; Kontinnen et al., 2019) participants noted the use of compensatory behaviours in seeking to regulate these secondary emotions, including walking (n = 12),

fasting (*n* = 4) or restrained eating (*n* = 10). The underlying reason for engaging in compensatory behaviour was due to worries about weight gain and the associated consequences on their physical health. Lina noted:

> *I have knee bad and my hand problem, so, and losing weight, that will help me to solve some of this, and even my, I have asthma. When I am overweight, when I go upstairs, I feel, I can't even breathe properly, so I think losing weight is, will, will alleviate, or resolve some of my health issue.*

Similarly, Suzie noted: "*I gained around 12 or 13 kilos, which is not good for my, for my health*". There was once exception to this, with one participant engaging in compensatory behaviour due to the desire to have slimmer body in preparing to get married and being perceived as attractive.

5.3 Theme 2: Factors Perceived as Influencing Emotional Eating.

When exploring 'factors perceived as influencing emotional eating' deductive coding was utilised to identify psychological, biological, and psychosocial influences informed by the contentions and findings of existing literature and theories of EE (Bruch, 1973; Siren & Sanlier, 2018; Al-Qarni, 2019). In doing so, the ten cultural considerations advocated by Moran et al. (2011) were also accounted for whilst coding psychological and psychosocial influences. Inductive coding was also used to ensure the culturally unique lived experiences of participants were represented (Byrne, 2022). As an illustration, the psychosocial influence subtheme `cultural etiquette` and ` religion' was identified through inductive and deductive coding. Whilst previous literature has identified religious barriers in expressing emotions (deductive), fasting during Ramadan and implications for EE were identified (inductive) from the data.

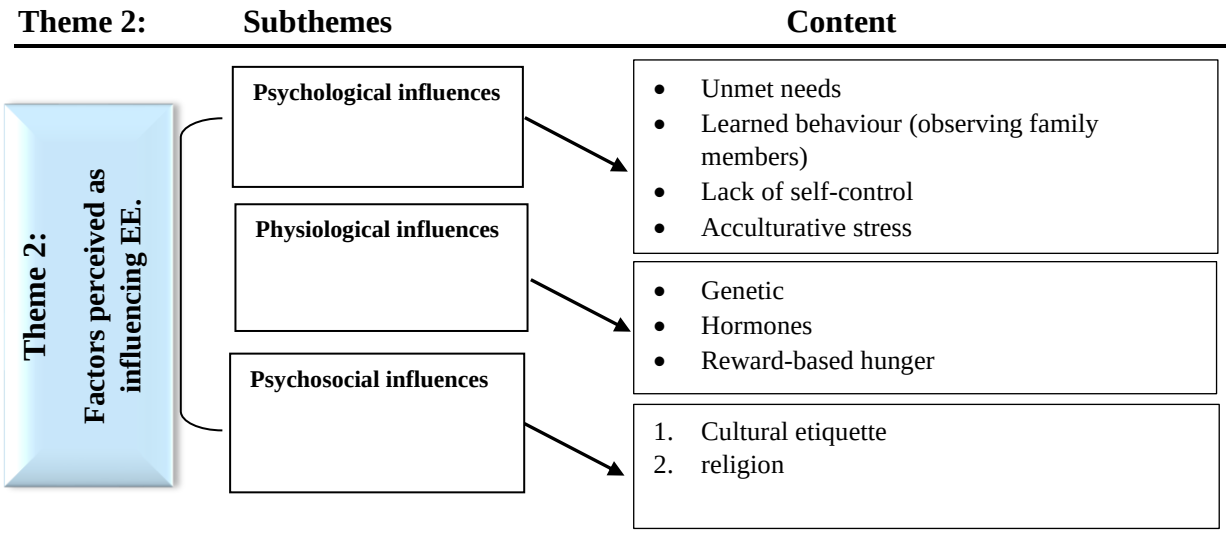

Figure 5: Factors perceived as influencing emotional eating.

5.3.1 Psychological influences

Participants described various psychological factors they perceived as influencing EE. For example, Aryan perceived unmet needs as leading to an increase in her EE, "I see EE as something that kind of, if, if something is missing at the time, I am kind of replacing that with food, I guess". Unmet needs included affiliation needs resulting from living away from family members, and a resultant lack of emotional and practical support (Serin & Sanlier, 2018). For example, Shna noted: *"maybe it's because I'm away from my family, and, and more stay at home."* Aiman notes: "*UK again, even though you can very often, and you are allowed to go out, you are allowed to drink, you are allowed to see friends, unfortunately everyone is busy".* It appears that participants experience of living overseas without the availability support from friends and family influenced their psychological wellbeing and contributed towards, feeling sad, bored, as well as experiencing worry about their family back home.

Another reported unmet need resulted from cultural attitudes/disapproval towards sharing unpleasant emotions and events with others, which was regarded as bringing shame to the family (Edge & Bhugra, 2016; Sayeed, 2003). Research indicates that in westernised culture individuals are encouraged to express and experience emotions (Davis et al., 2012), whereas in Middle Eastern culture, individuals conceive emotions as being located in the relationship with others and value the group they belong to (family/tribe), encouraging individuals to control emotional expression to protect social relationships (Al-Qarni, 2019).

Research has highlighted that psychological health and well-being are linked to how effectively emotions are regulated (Frijda, 1986; Kobylińska & Kusev, 2019). In line with previous research undertaken with Middle Eastern populations (Lim, 2016; Tahmouresi et al., 2014; Zolezzi et al., 2018), suppression and repression were commonly used as an emotional regulation strategy among participants. The use of suppression and repression has been associated with EE among adults (Ferrer et al., 2017; Racine et al., 2019; Sultson & Ackermann, 2019) and adolescents (Ferrer et al., 2017; Vandewalle et al., 2016). The use of these strategies was often described by participants. Cey noted: "*we are not you know, letting our emotions out, we are not talking about it, we are just letting it out on different things. I found eating and picking food is just you know, it's a comforter for me".*

Similarly, Noah noted:

> *In our culture it's not very like, very common that you talk about your emotions, so it's a shame for me to yeah, to go somewhere and tell them about my things or my problems, or anything that has to do with me…you are almost ashamed to talk about anything, especially like, about your emotional eating.*

In a further illustration Mina noted:

> *Well it's a cultural thing you know, you need to be strong, you need to, it's different from here, you know, when you expose your emotions here, you will be listened to, but in our culture, the, people encourage you to be more strong, so if you know, expressing some emotions they would say, you are a weak person.*

This could be due to stigma around mental health, seeking help, and disclosing information to someone outside the family, which can be perceived as negative, betrayal, and shameful (Williams et al. 2006; Irfaeye et al., 2008; Sayed, 2003). Egan and Fox (2017) propose that attitudes towards emotional expression can directly affect a person's belief about the need to control the expression of emotions. According to the Affect Phobia Theory (Egan & Fox, 2017) an environment in which the expression of emotions is disapproved of can lead to emotion suppression or repression and emotional dissociation from oneself. This can constrain the expression of emotions resulting in emotions being managed through different coping strategies such as eating. Participants described how cultural values and norms were learned during early life experiences regarding the sharing of unpleasant emotions, and thus they learned to use food to as an alternative means of managing emotions. Samira, reflected: "*Mostly I think it's expressed by eating... I think in our culture, it's like a taboo subject, you know, somebody speaking about their problem* ". Rula stated:

> *If my mam or my dad are sad, they would never come out and say, well I am sad because of this you know, they would keep it either between them or they would keep it for themselves, so it's still a very difficult thing I think, for somebody in our culture. So I think it's mostly linked, the food is sort of linked to, to give them feeling happy most of the time, because most of them, or most of us, they don't express it.*

This highlights how emotion processing is shaped by culture, with culture-specific norms influencing the intensity, frequency, and appropriateness of expressing emotions in general, and particularly during social interactions (Lim, 2016). Such cultural awareness is important for health care professionals and can have direct implication for culturally tailored interventions intended to decrease stigma for Middle Eastern populations, and thus promote normalising help seeking behaviours for mental health treatment. In an illustrative example, when using self-report measure during an assessment, psychological difficulties may be underscored by this population. In this regard, Gopalkrishnan (2018) argue that careful questioning can be the key to elicit psychological difficulties when working with non-westernised cultures.

EE as a learned behaviour was identified as a further psychological influence. Research indicates that the propensity for food consumption in response to unpleasant emotions can gradually increase through stimulus-response conditioning (Booth, 1994; Hawkins & Clement, 1984), thus enhancing motivation to eat when experiencing unpleasant emotions (Nyklíček et al., 2011). Bruch (1973) notes that this conditioning begins from a very early age, for example during breastfeeding whereby children are provided with food in contexts of emotional significance. Several participants reported learned EE behaviour from childhood. Cey noted: *"I remember when my auntie's upset or if anyone is upset, the adults, when I was a child, they just bring food""* Classical conditioning theorists suggest that food intake is an unconditional stimulus (US), and that food signals systemically paired with food consumption predict intake (Bongers et al., 2015). Jansen et al. (2011) proposed that emotions can become food-signalling. Participants including Diman offered support for this contention: "*To my understanding, I can see that my emotion can control my eating habits*". These findings indicate that participants may benefit from information and awareness of the relationship between stimulus, conditioning and emotional eating.

Elfgha and Morey (2008) propose that poor self-control is a central mechanism of emotional eating. Aryan shared insight into her experiences with self-control, *"I think I don't know until I've done it like it's, it's only after that I have realised kind of, oh, that felt like you didn't have any control*". Davis and Claridge (1998) reported that unpleasant emotions could weaken the cognitive control of eating and thereby enable a propensity to overeat. They suggest that this is because the regulatory efforts in selecting, preparing, and consuming a healthy food choice may be too much for an individual seeking to regulate unpleasant emotions and thus already depleted. This was evident among participants, for instance Deman explained: *"probably just eat that thing without any control. If something is not like, you know in a, in a normal situation, I'm not eating that much, I think that is, I have more control to stop it."* Whilst Aiman noted:

> *It's just really hard, because sometimes I don't know, I'm not going to eat something, I'm not going to do this, no, I need to control my diet, and I just find myself even more stressed, trying to stop myself not going to grab anything. So I just say, okay, it makes it easy, the easy way, and go eat. I just choose the easy option*.

According to Marques et al. (2020) food choices during EE may be driven by impulsive tendencies and not rational considerations, and for some individuals as it can become more challenging to resist impulse-related unhealthy food choices when experiencing limited self-control. Several participants highlighted the self-control required in preparing healthy meals. For example, Aiman noted:

> *Biscuits or chips, I go more to these ones, you know, easy to eat, something easy, not something I have to prepare or something … because I feel at that time really, just want to lay down, do not want to work at what I'm eating, so I go for the easy option*.

Baumeister et al. (2007) propose that behaviour which requires self-control (such as emotion regulation) utilise resources, and that low availability of resources, despite being perceived or not, can explain poor self-control. In support of this argument, research has evidenced that when a person attempts to manage their emotions by, for example, suppressing their unpleasant and unwanted emotions can lead to increased food consumption (Evers et al., 2018).

Since moving to the UK, some participants noticed challenges such as acculturative stress, social disadvantages, and being away from family as contributing to EE. For example, Shna noted: *"when I moved to the UK, my eating, my emotional eating was more and I know because of the stress, because of being alone a lot, or thinking about family".* Whilst Lara noted*:*

> *In the UK, since I have moved back here, eleven years ago I started university again this had a very stressful time, so I got my own place, I used to be in a friend's house for three months and then, I was a single mum studying, working, doing Uni placements, went through a lot of hard times, then I started losing you know, the eating habit again* [referring to healthy eating], *so not only because of that, because I never had time to exercise.*

This has previously been reported among first generation immigrants (Klein et al., 2020), with acculturation demands leading to stress, anxiety and depression (De Oliveira et al., 2017). A consequence of this being an increased likelihood to seek comfort through consuming food (Doumit et al., 2016; Wilson & Tyler, 2018).

5.3.2 Physiological influences

When deductively coding for biological influences, there was evidence to suggest that EE behaviours could be partially explained through hedonic or reward-based hunger, which occurs from the desire to consume highly palatable food rather than eating due to physical hunger (Siren & Sanlier, 2018) This can override the homeostatic pathway amid periods of energy abundance by increasing the urge to eat (Lutter & Nestler, 2009). This was illustrated by Aiman who noted:

> *I can have maybe like, two packets of crisps, but then continue with like, maybe two chocolate bars, and it's not like, at, at the time of eating it, I'm not like registering that, I'm not even hungry like.*

Research indicates that highly palatable foods reduce the stress response activities of the hypothalamic-pituitary-adrenal Axis (HPA) through activating the reward centre of the human brain (Adam & Epel, 2007). Modifying extracellular dopamine levels through the consumption of sugary foods has been found to allow for experience happiness, joy and comfort (Güleç Öyekçin & Deveci, 2012; Siren & Sanlier, 2018). Kalon et al. (2016) compare these effects to the effect of social drugs and the activation of the mesocorticolimbic system. These outcomes can increase the motive and desire for sugary foods and thus perpetuate EE habits (Ulrich-Lai et al., 2011; Ursano et al., 2009).

Participants expressed their beliefs about various biological factors involved in EE. Zizi disclosed: "*Maybe heightened hormones during the menstrual cycle or pregnancy*", Shan noted: *"emotional or hormone sometimes"*, whilst Mina Noted "*When we go and get married, things change in our body because of pregnancy and change of hormones. Then my eating started*". Culture regularly portrays that women crave sweet food such as chocolate, particularly when approaching menses (Bratskeir et al., 2015). Although this may not apply to every woman, there is evidence of gender differences, not just food cravings but also

clinical characteristics including severity, frequency, and management of EE (Osman & Sobal, 2006; Hallam et al., 2016). A complex interplay of biopsychosocial factors is likely to account for these differences, with sex hormones such as progesterone, estrogen and progesterone widely understood to drive gender differences (Hallam et al., 2016). This reflects the participant's view of biological factors which may contribute towards EE. Indeed, research has evidenced variation in food consumption across the menstrual cycle due to fluctuations of sex hormones (Asarian & Geary, 2013; Eckel, 2011).

5.3.3 Psychosocial influences

When coding for psychosocial influences, Moran et al. (2011) suggest that culture sets the norm of a particular behaviour for society, such as emotional expression, the expectation of how individuals should feel during certain life events and how they respond and manage emotions and events (Luomala et al., 2009). Therefore, considering cultural effects is of value when exploring emotions and management, EE, and obesity prevention (Leersnyder et al., 2015), and this was guided by the ten considerations of culture identified by Moran et al. (2011).

Participants felt that cultural etiquette could present challenges in managing their emotions and EE. Culture is universally known as a set of learned beliefs and behaviours shared among a member of group, which is influenced by language, history, customs, religion, family structure and environmental factors (Linnard-Palmer, 2017; Moran et al., 2011). Moran et al. (2011) contend that food and eating habits are a fundamental part of any culture, including food selection, presentation, and eating. Indeed, this was experienced and shared by all the participants. Samira noted:

> *Being you know, an Arab Muslim is, I think food is at the center of everything, whether it's a sad occasion, or mostly you know, the happy occasions, there is always*

food, there is always sugary, so they are always unhealthy, and the food it always comes before anything else.

This highlights that culture may influence how individuals express and cope with emotion through their EE patterns. Including eating out, cooking with family/friends, and treating self with food (Luomala et al., 2009; Roohi-Booroujeni, 2022). For example, Luomala et al. (2009) found that individuals from collectivist culture associated social and everyday eating activity with both pleasant and unpleasant emotions whilst individuals from individualist culture linked social and luxurious eating patterns with pleasant emotions, whilst rejecting social and luxurious eating activities in response to unpleasant emotions.

This therefore indicates that social-EE patterns may be more predominant among collectivist cultures. Whilst an a-social emotional-eating pattern may be more dominant in individualistic cultures. However, whilst food can help people connect, for Middle Eastern individuals this can present a barrier to the management of their EE, particularly for women. Participants grew up associating food with connection, sharing moments with others, and way of coping with emotions (McCullough, 2003). Gender role expectations of women within Middle Eastern culture includes prioritising the needs of children and partner and expectations of preparing and presenting daily meals to convey care and love (Al-Bkerat, 2019; Hassan et al., 2010). Noah noted: *"Food is very important, because it brings like, it brings you together as a family"*. Outside of family meals, for Middle Eastern women the worthiness of hospitality is often judged by the amounts and variety of food types offered, including rice, meat, and sweets (Stephenson & Ali, 2018). Aiman noted: *"If you are going to visit a friend and have fun, you have to take food, you have to prepare food, so food is a big thing in my culture"*. Donnelly et al. (2021) report that in receiving hospitality Qatari women felt pressured and obliged to eat food offered despite knowing that they were unhealthy

foods, which could lead to unpleasant emotions. These pressures to consume food presented as acts of hospitality were identified by participants. Aryan noted:

> *If you are on a dinner table with other people, and like you get offered like more food, and you don't accept it, the people would think like, you don't like their food or like, they would never think, oh she's just kind of like, watching her weight and stuff like that. So there is just, it's really difficult not to kind of accept food.*

This finding supports previous research regarding the social facilitation of over consumption resulting from not needing or being able to restrict food consumption due to the need/desire to maintain a good impression, and in making others feel welcomed (Stephenson & Ali, 2018).

Cultural expectations of Middle Eastern Women to eat with children and their husbands (Assaad et al., 2017) created further instances of overconsumption; Noah shared: "*I already had my dinner and then more like, when I eat again with him* [husband]". Similarly, Zizi noted: "*my lunch at between one and three, and then when my husband came also, I try you know, just socialise with him, so I try to eat just snacking with him*". Participants also shared their experience of engaging in different food practices based on the occasion. For example, eating appeared to be associated with quality time, particularly with partners. Cey noted: *"my husband came back from work, get the crisps and the Diet Coke, we are watching football. So, see, so watching football is never empty-handed or empty mouth*". Suzie shared: "*When I am walking, me and my husband, we take seeds with us, you know, the pumpkin seeds or the, yeah, we take it just because we are talking and we are walking, and we having some, something to enjoy"* Whilst food allowed participants to connect with their family, this also created a pressure and expectation to eat with their children, husband and visitors, manifesting in guilt due to overconsumption of food, or shame around not eating with others

and how this may be perceived. Addressing such cultural considerations is important when offering interventions intended to help individuals manage EE.

Cooking a variety of food in large amounts was associated with generosity within the Middle Eastern culture. Lara noted:

> *They relate it to being generous, generosity, so, so people would talk about, oh this house they are very generous. Oh, that house, they cook the best food, oh that house they throw the best parties for example, so it's all about showing off as well, and, and now at this age*.

Similarly, Noah noted: *"like in our culture it says a lot about you what you bring on the table for like, food, especially when you go for dinner*. The worthiness of the hospitality is judged based on the food provided (Stephenson & Ali, 2018). For example, one participant receiving positive comments from her partner appeared to increase her motivation and confidence. Noah noted: *"When my husband gives me credit for the things that I made, it will motivate me to be even better the next day. So that's also emotions because you get a reward for something you did, "*. In addition, a study conducted among Arabic and South Asian women reported that cooking and serving food at their husband's and children's requests served a symbolic power (Vallianatos & Raine, 2008). This suggests the importance of understanding the symbolic meaning and association with food to understand an individual's subjective construction and how social-cultural boundaries are demarcated.

Maintaining cultural identity was valued among participants highlighting the importance of cultural considerations when working with non-western individuals (Hays, 2019). Indeed, participants reported a desire to preserve their culture through food practices and pass this on to their children. Although most participants reported a preference for traditional food, they would also cook westernised foods as their children preferred this. This

meant that different meals would have to be prepared at the same time, which has been reported by numerous studies undertaken among immigrants (Trofholz et al., 2020; Vallianatos & Raine, 2008). This influenced their eating patterns and family routine, often leading to overeating, particularly for participants with partners who worked until late at night. Samira noted:

> *I don't have three main meals, because, because I mean, it's just chaos our life, it's not easy with them, and they have different eating habits, my daughter and my son, so I make different foods for them and they have different hours that they eat, so it's not like three main meals, and we just sit down and eat. It's not like that.*

In summary, this subtheme indicates that understanding the relevance of the cultural identity of the target population can aid practitioners and researchers in exploring EE and associated interventions (Bisogni et al., 2002).

The influence of religion on EE was identified in the present study. All participants identified themselves as Muslim and followed Islamic guidelines. There is growing evidence regarding the role of religion in consumers' behaviour, including eating behaviour (Elshaer et al., 2021; Minton et al., 2015). Religion can play a significant role in shaping the individual's belief system, knowledge, and social values, and therefore, the significance of religion cannot be separated from the person (Abu-Alhaija et al., 2017). Ten participants considered their faith as an essential part of their day-to-day life, for instance, they reported that their religion stresses the importance of a balanced diet and retaining an active lifestyle. However, participants found this lifestyle difficult to maintain, noting that poor adherence to a healthy lifestyle led to experiencing unpleasant emotions such as guilt or frustration. The recommendation includes ‘The son of Adam cannot fill a vessel worse than his stomach, as it

is enough for him to take a few bites to straighten his back. If he cannot do it, then he may fill it with a third of his food, a third of his drink, and a third of his breath' (Sunan Ibn Majah, Hadith 99). Suzie notes*: "I prefer to follow what prophet Mohamed said* [referring to Prophet's habitual practice] *what he told us, about how to eat, what to eat and when to eat… sometimes I, I say no, it's not good, you have to stop, it's not healthy ".* The incongruence between what participants wanted to eat and what is expected from a religious perspective appeared commonplace among the participants, lending support to Moran et al. (2011) who purpose that religious traditions can consciously or unconsciously impact a person's attitude towards life.

One participant stated that Ramadan helps her realise that she capable of making changes to her diet if she puts effort into it, Shna "*I realise that's all about the brain, so I can train my brain about that, and I need to do, be aware of what I'm eating".* In line with previous research, spirituality and religiosity can have a negative, positive, or non-significant influence on eating (Akrawi et al., 2015). Betul noted that overeating was perceived as having a lack of control:

> *There is some religious values, like overeating is not a good thing, because I mean it's, it means that you can't control your inner self, like lower self, so it means that you are not a good servant of God, because, I mean you can't control your instincts and your animal side, because eating is associated with body actually, is associated with more animal side of a human being.*

These illustrative examples show that when participants succumb to emotional overeating, they experienced unpleasant emotions because they perceived themselves as failing to comply with the expectations of their religion.

5.4 Theme 3: Recommendations for culturally adapted Emotional Eating interventions

A deductive approach was used to identify participant experiences (or not) of professional help for EE, and barriers to accessing support. Inductive coding was used to identify participant's recommendation for culturally adapted interventions intended to manage EE (see Figure 6).

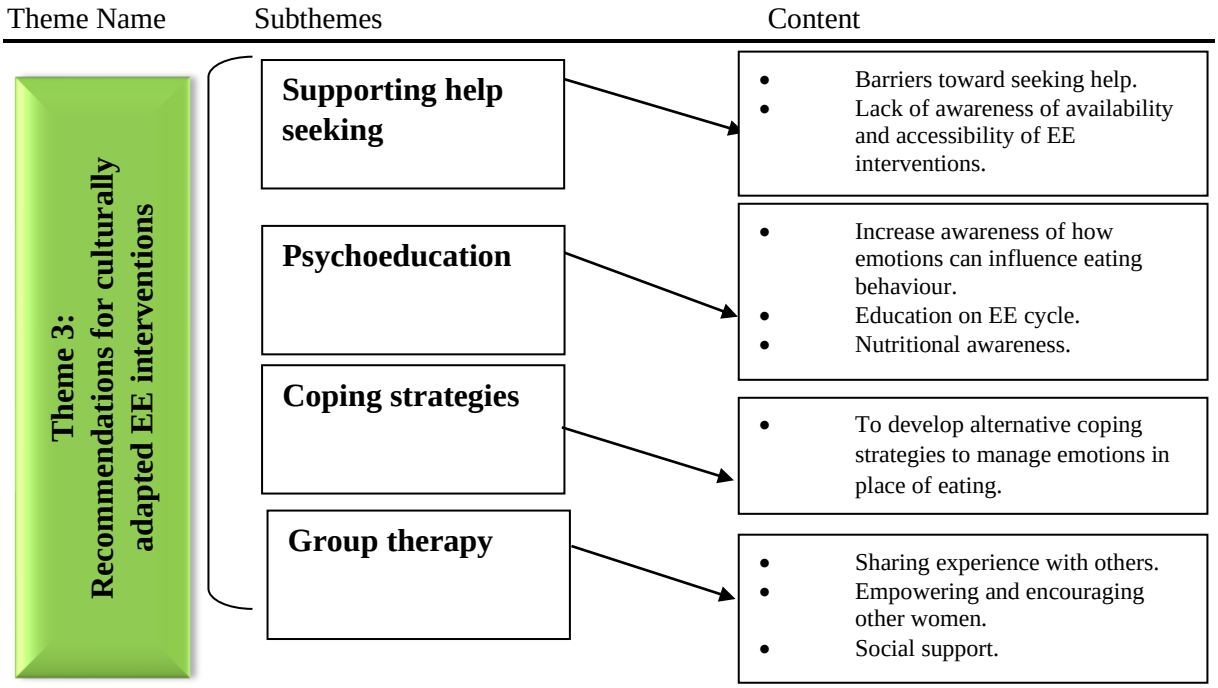

Figure 6: **Recommendations for culturally adapted EE interventions**

5.5.1 Supporting help seeking

In support of previous research, cultural upbringing appeared to influence help seeking. For example, *"when it comes to sad or feeling frustrated, or useless and things like that, you are not supposed to say that; what will people say about you, and because of the culture, sadly"* (Cey). This may be explained through beliefs among collectivist cultures that the expression of unpleasant emotions and life events may damage the reputation of or bring shame to a family/tribe's reputation (Krstanoska-Blazeska et al., 2021). Some participants described how

expressing difficulties could be perceived as complaining and being unhappy with god's decision, and so emotions should be repressed and not expressed (Musleh, 2017). Cey noted:

> *Expressing ourselves was as if it's against the will of God, it's like oh, you are complaining, you are not supposed to complain, this is what god decided for you, so you just shut up and get on with it.*

Research also indicates that in Arabic cultures mental health difficulties are associated with possessions, black magic, or punishment from Allah (God) for engaging in sinful acts (Alharbi et al., 2020). This may explain why seeking professional help for mental health difficulties remains low among individuals from a collectivist culture in the UK, including among Arabic individuals (MHF, 2019). As a result, some individuals dealt with their issues through either repressing emotion, seeking help from religious resources such as duas (prayers) and reciting the Holy Quran, or alternative coping strategies such as EE.

Furthermore, in seeking professional help, among participants, 13 were unaware of interventions for EE available via the national health care system: *"I have never heard anything about it, and I haven't thought about it"* (Betul); "*No, I haven't, it's just, it's simply because I have never had the opportunity to, you know, to participate in anything or I wouldn't know where to go to sort of, participate."* (Samira). These findings align with the findings of Memon et al. (2016) when exploring barriers to accessing mental health services among BAME populations and suggest that culturally adapted interventions accounting for cultural and religious beliefs could improve treatment access and outcomes.

5.5.2 Psychoeducation

Within theme one 'participants understanding of EE' all participants identified a desire to learn more about identifying emotions and the influence of these on their eating behaviour. Psychoeducation refers to increasing knowledge about how situations or unpleasant events

can trigger particular thoughts and emotions, and the influence of these on behaviour. In the case of the present study, and in particular this subtheme, the behaviour of interest is emotional eating.

For example, Amina noted:

I know it will be beneficial for me to know even more in detail why I'm doing it [EE], *how I'm doing it, what exactly I am doing to maybe, to record it step-by-step because I think when I know exactly the problem, and how it happens, when it happens, help me more try* [motivation to change], *it will help definitely for me.*

Similarly, Betul stated a desire to increase her awareness of physical and head hunger in order to better manage this *"I think the connections in our minds and eating should be discussed, and every time we eat something, not out of the need, bodily need for it, but just psychological need".* Researchers suggest that EE interventions should not only focus on changing eating behaviour but also emphasise individuals' emotional functioning and relationship with their eating for better outcomes (Bernat et al., 2020).

There is evidence for the effectiveness of Psychoeducational interventions which involves educating clients on the relationship between emotions and eating, impulse control, stress and eating, and reward motivated eating (Armitage, 2015; Lattimore, 2020). Such interventions are often brief interventions integrating techniques such as mindful eating or CBT delivered one-to-one or in a group. EE intervention programmes such as mindful eating have been successful in improving the health and wellbeing of emotional eaters (Sarto et al., 2019). However, it is important to establish existing perceptions around EE, eating habits and eating patterns among a target population when developing interventions (Yumuk, et al., 2015), and cultural factors must be specifically considered when working with non-westernised individuals to produce better treatment outcomes (Regnault et al., 2018). There is

clear evidence that culture significantly influences EE and treatment-seeking motivation (Luomala et al., 2009; Meyer & Zane, 2013).

Participants expressed a desire to increase their understanding of EE and subsequent ability to regulate this. For example, Noah noted:

> *I just want to have some answers about these things, why does it work for me like that, I can't help it anymore at all, so I don't know how these kind of emotions they have, and how that is related to each other, but my, my combination is being sad and eating unhealthy.*

Cey noted: "*it* [an intervention*] should include how to build insight, how to be insightful of your thinking, because EE it happens in less than a second, so it's about realising that I want to emotionally eat now".*

There is growing evidence showing the effectiveness of mindfulness eating, whereby participants are taught to accept and tolerate unpleasant emotions leading to healthier eating (Lattimore, 2020). When working with individuals from Middle Eastern culture, it is important to consider cultural attitudes towards sharing and expressing unpleasant events/emotions. This should include consideration of cultural and religious barriers, as well as understandings of mental health, and gender role expectations (Dardas & Simmons, 2015; Krstanoska-Blazeska et al., 2021; Zolezzi et al., 2018). Accounting for these considerations will lead to culturally sensitive interventions and thus move beyond the one-size-fits-all approach (Purgatory et al., 2021).

5.5.3 Coping Strategies

The subtheme 'coping strategies' provides a summary of alternative (to EE) coping strategies that participants perceived as useful to consider in an EE intervention. Fourteen participants indicated that they would like to learn to manage their emotions using alternative techniques

rather than seeking out food. Diman noted*: "I would want to have other alternatives, which I can you know, use when I have like, emotional difficulties rather than just you know, taking revenge from food probably".* Cey noted*: "So for me personally, it's not about losing weight, it's about being able to control my feelings, and my emotions, and also not letting food control me. For me that's a successful intervention".* Research has indicated that poor self-control to regulate own emotions can greatly influence disordered eating patterns including EE (Izydorczyk et al., 2019). As such learning to control food cravings can be an effective strategy to help reduce EE. Aryan noted: "*I need to learn about like, how to initially stop myself, so like when you have that first initial craving like, or I really want like, a chocolate bar, what to do in that moment".*

Adaptive and maladaptive strategies participants were already utilising in an attempt to reduce EE included suppression, repression, distraction, walking, meditation, and connection with family/friends to reduce emotional distress. Some of these alternative strategies were reported to be useful such as walking and distraction (e.g., going out with a friend). For instance, Aryan noted: "*Yeah, so I try sometimes to go for a drive, and maybe listen to music, do these things*". Similarly, Lina stated: *"tried to make myself busy. I started to sort out my baby stuff, change and feed her, and like, trying to distract myself … Sometimes it's helpful, but sometimes no".* Another distraction method reported by participants was seeking social support from family and friends. Lara noted: *"maybe meeting a friend, talk on the phone with someone, you know, things like that*". Some suggested that engaging with others compensated for unpleasant emotions, including loneliness, boredom and feeling down. For example, Rula reported:

> *I sometimes, I try to go outside the home, the worry, because I don't want to be bored, so I go for shopping or any, going to meet for friends, or taking coffee outside, even if I, I want to let you know, so if I go with my friend to have breakfast to be*

honest, I don't feel hungry at all, just having a black coffee and I am very happy, but if I return back in myself you know, I start thinking about my, my problem or my stresses or my you know, anything, I start, I want to eat anything now.

This highlights a need to account for strategies that participants already find useful in developing EE interventions (Frayn et al., 2018). Research among Middle Eastern populations suggests that when Arabs are faced with psychological distress, they tend to seek out family members for help and guidance (Nehme, 2018). However, in the present study, participants stated that at times, they avoided sharing emotions with their parents due to fear of causing stress and anxiety to the family. This could perhaps be due to living in different countries. Furthermore, no participants described talking about their difficulties in-depth with friends but instead used socialising as a distraction.

5.5.4 Group Therapy

In exploring participants recommendations for a culturally adapted intervention, social connection was deemed important for participants. Eleven participants felt that they would benefit from group therapy, whilst the remaining participants indicated that they would be happy with either group therapy or one-to-one therapy. Literature suggests that a group approach offers the following advantages: peer interpersonal feedback, sharing emotions and experiences, and group cohesion (Burlingame et al., 2013; Grenor et al., 2017). For example, Fairburn (2008) found that individuals who participated group psychotherapy were five times more likely to refrain from purging and binge eating compared to participants on a wait-list control. Participants in the present study indicated that group therapy may assist in managing unpleasant emotions through sharing emotions and difficulties, feeling less lonely through connecting with other Middle Eastern females, being able to see that they are not the only one looking to manage EE, feeling understood, and supporting and empowering each other.

Samira noted:

> *When we see other people going through the same thing, maybe it could help a few people to think, well we are not the only ones, and this problem is, it is recognisable, and it is a problem. I think it will be, it will help a lot of people.*

Lina noted: "*in group we can talk about this, we all have the same problem, and we can walk together, like each one is encouraging each other to."* Sinha and Warfa (2013) conducted a systematic review exploring the utilisation of psychotherapy, referral of and access of ethnic minority for treatment of eating disorder with westernised cultures. This included the role of acculturation and barriers to seeking help. They found that minority communities in the USA and UK were less likely to seek and receive treatment for eating disorders. However, they also found that the more an individual was acculturated the more likely they were to seek treatment for an eating disorder. In the present study, participants indicated and were open towards group therapy which may be a result of living in a westernised country and acculturation.

In conclusion, in line with existing research, participants perceived unpleasant and pleasant emotions as eliciting EE (Devonport et al., 2018; VanStrien, 2018). Individuals tended to consume foods high in sugar and/or fat to deal with difficulties, or in respect of celebratory, religious, or cultural events (Firthy et al., 2020). However, as well as foods high and sugar and fat, foods that provided meaning for the Middle Eastern women were also selected during EE episodes. Participants would often choose typical Middle Eastern foods linked to their culture such as rice and pastry. When experiencing emotions such as anger, some participants would select food such as apples or cold rice, due to the sounds and sensations these foods created during chewing. This illustrates how cultural influences can

play a role in EE and it is thus essential to consider such influences so that interventions are acceptable for the individuals.

Regarding consequences during and after EE, participants all described experiencing satisfaction and enjoyment initially during EE, however, these short-term emotions quickly gave way to feelings of guilt, shame, and concerns regarding overconsumption, consumption of poor foods and weight gain, for many this was linked to religious values and beliefs regarding self-care specifically with regards diet. This would often trigger compensatory behaviours such as exercise. Participants requested that any EE intervention explored their needs and helped them in learning different ways of coping with their emotions rather than eating. A further benefit of such psychoeducation was identified in that half of the participants perceived EE to be caused by biological factors such as hormones or genes.

This may be related to the non-westernised population being more accepting of physical illness than mental health illness (Irfaeye et al., 2008; Melisse, Beurs & Furth, 2020). In particular, the stigma around sharing unpleasant emotions or events was perceived as a barrier to managing emotions and EE. Indeed, sharing difficulties was perceived as not being encouraged growing up. Also perceived as influential was cultural etiquette and the expectation of women and associated roles in Middle Eastern culture. This included prioritising the needs of their children and husband over their own needs, types of foods being cooked, and sharing information with someone outside their family. However, participants felt that having moved to a Westernised culture has helped them to be more open and thus willing to engage with other Middle Eastern women in an EE intervention within a group setting.

CHAPTER SIX: The Development of a Culturally Adapted EE Intervention for Middle Eastern Women using Patient and Public Involvement and Engagement (PPIE)

This chapter describes the use of PPIE in informing the development of a culturally appropriate EE intervention. The rational for the use of PPIE will first be described, followed by an account of the PPIE that took place during intervention planning. Finally, the content of the interventions will be presented.

6.1 Rationale for PPIE

The importance of PPIE in developing health interventions has been widely recognised (Muller et al., 2019). Interviews undertaken in Phase 1 enabled an in-depth understanding of the experiences of Middle Eastern women living in the UK with emotional eating, and also identified recommendations for the development of EE intervention for this population. Fletcher et al. (2016) note that interviews provide useful insights into the requirements for intervention design, for example by examining the perceived need for and acceptability of alternative intervention types among representatives of the end user population. Muller et al. (2019) suggest that PPIE has a solid ethical value as it ensures that the views of service users and patients are represented in the project. This allows the intervention to focus on the factors and aspects important to the targeted population. Tsai (2022) proposes that it is crucial to understand how cultures have shaped an individual's emotional life and influenced their well-being. This will enhance the study of human behaviour and advantage multi-cultural society, thus involving participants in the development of the intervention may increase positive outcome.

In summary, PPIE has been utilised for several reasons; firstly, research suggests that meaningful PPIE benefits research in various ways, including acceptability, accessibility,

feasibility, and relevance of hypothesis, and it enhances adherence to the experimental protocol (Iliffe et al., 2013). Secondly, PPIE can enhance the quality of research as it helps develop user-friendly materials in line with participants objectives (Brett et al., 2010; Den Breejen et al., 2016). Thirdly, PPIE, if well planned, helps participants gain new skills and experience and thus feel more respected, valued, and better represented (Devonport et al., 2018). PPIE participants often bring new insight and momentum to research and, thus, potential intervention to help.

6.2 PPIE Guiding Intervention Planning

PPIE was conducted using a co-production approach, which means that PPIE participants and researchers worked together to develop the culturally adapted intervention. In other words, co-production refers to coming together to find a solution, which means that participants are meaningfully involved from start to finish of the research process (Keane et al., 2023). This was vital as it aligns with an ethnographical research design and the researchers' epistemological positions helping to ensure that phase two was not solely based on the researcher's interpretations.

PPIE was utilised to involve representatives of Middle Eastern women in the process of developing a culturally adapted intervention to manage EE. This would help to accommodate cultural considerations, including emotional expression, help-seeking behaviours, social environment, and cultural relationships with food (AlNohair, 2014). Given the relatively low representation of this population within the focal geographic area for this study, the 16 Middle Eastern women who took part in phase 1 were approached via email to ask whether they would like to take part in PPIE. This meant that the same participants (12 out of the 16 volunteered for PPIE) who participated in phase 1 were involved in the PPIE process. The benefits of undertaking PPIE with the same participants are: 1) they were

involved in phase 1 and so familiar with the aims and objectives for intervention development had expressed a desire to be engaged in PPIE (Devonport et al., 2018; Le Master, 2020; Prost et al., 2013), 2) they had provided recommendations for a culturally adapted EE intervention, and their involvement enabled continuation in seeing these recommendations integrated during intervention development, and 3) there was difficulty in recruiting Middle Eastern women who met the inclusion criteria from an already small sample pool, and doing so within the strict time limit for thesis completion meant that the use of willing volunteers to PPIE was a pragmatic solution.

During PPIE, the findings from the phase 1 alongside recommendations for EE intervention development from existing intervention literature (e.g., psychoeducation, mindfulness, and CBT) were shared via a PowerPoint presentation with the 12 PPIE within a group meeting taking place via Zoom. Informed by this information, and in reflecting on their own experiences, they were asked to provide feedback regarding the content and details of a proposed culturally adapted intervention intended to help understand and mange emotional eating. To facilitate this, participants were asked to reflect on questions presented in Table 2. The questions were beneficial in helping PPIE members to discuss what they would like the intervention to look like. Regarding obtaining consensus, the "raising hand" option on Zoom was used for some questions, such as 'time of the intervention'. Regarding the preferred intervention approach, this was discussed as a group whereby they agreed on the importance of psychoeducation, identifying triggers for emotions and problem-solving techniques.

Table 2: Summary of PPIE Questions and Associated Feedback Regarding Intervention Development

Topic	Questions asked	Feedback
Intervention needs	Q1: Having heard the findings from phase one interviews and existing interventions, what are your thoughts and what would you like the intervention to cover.	To learn about mind and body connection (*n =12*) To learn to identify triggers for EE (*n =12*) To learn about the impact of EE on health (*n =10*) To learn to use different strategies to manage emotions (*n =12*)
Preferred time	Q2: Are you more likely able to attend the session in the morning or afternoon	During school hours due to lack of childcare (*n =10*) On weekends due to work commitments (*n =2*)
Preferred method of delivery	Q3: Would you prefer the session to be conducted face-to-face or online?	Face-to-face (*n =10)* Online (*n = 2*)
Location and commuting	Q4: Will you be able to commute? If not do you have preferred location?	Able to commute if within Birmingham (*n = 5*) Unable to commute and therefore preferred walking distance location such as community centre (*n = 7*)
Duration of intervention	Q5: How long do you believe an intervention should last per session?	Between two to three hours.
Number of sessions	Q6: Are you more likely to attend short or long therapy sessions?	Majority shared being open to short therapy session due to commitments and being new to therapy (*n = 9).* Others were not sure (*n = 3*).
Group or 1:1 therapy	Q6: Would you prefer group or 1:1 Therapy?	All participants identified a preference for group therapy.
Support after end of therapy	Q7: How can the research support you following the end of the intervention?	To remain in contact with the group and support each other (*n =12*) or being provided with self-help booklets (*n =2*).
Homework	Q8: Often as part of psychological interventions you may be given homework, what is your view on this?	All shared not having issues with completing simple and short homework worksheets. As long as it is explained how to complete the homework sheet.

6.3 Intervention Planning and Rationale

On listening to the findings from phase 1, PPIE members reported that their experiences were captured well, and that hearing their experiences relayed back to them left them feeling listened to. They expressed a desire to better understand emotional eating, and how to regulate emotions using alternative strategies, and felt that psychoeducation would be helpful. PPIE members agreed as a group (n = 11) that due to having little or no experience of psychological interventions, they would benefit from starting with psychoeducation, with their main goal being learning to problem solve and find alternative coping strategies to deal with their distress rather than emotional eating.

In listening to findings regarding the impact of cultural and religious beliefs on EE, PPIE members discussed how despite having moved to a Westernised culture, limiting the impact of cultural and religious beliefs was challenging. They felt that exploring religious and cultural influences on EE and receiving support whilst doing this would be helpful. In particular, in terms of stigma around mental health and sharing unpleasant experiences.

All PPIE members agreed that they would advocate group therapy because they felt that this would benefit intervention recipients in several ways. This included connecting with other Middle Eastern women with similar issues, discussing experiences such as difficulties with meal patterns (e.g., eating with children and husband), cultural etiquette, and cultural expectations in managing unpleasant emotions. They felt that a group approach with other Middle Eastern women would help them express their emotions, but also sharing and receiving ideas would be encouraging and supportive. Several PPIE members were of the firm opinion that participation in a group session will help individuals break the cycle of stigma and encourage them to express unpleasant experiences outside the session; one PPIE member said, “this is where we can start to practise” (referring to group session).

Finally, due to family responsibility, the PPIE members indicated that people would be more likely to attend the intervention if the intervention was a brief intervention, with sessions delivered during school hours (n = 10) in a nearby location. They also advised that sessions should be delivered face-to-face (n =10) due to limited computer skills, and/or not finding online interventions helpful.

6.3.1 Therapy modality

In reviewing the PPIE feedback and the results from the first study, culturally adapted CBT was considered an appropriate intervention to help understand and regulate EE. The CBT model proposes that problematic eating behaviours such as EE can be developed through classical and operant conditioning. For example, with unpleasant or self-defeating cognitions such as low self-worth leading to increased EE behaviours (Perri & Fox, 2005). CBT has different purposes such as addressing maladaptive thoughts and behavioural process that contribute to the maintenance of EE (Strodi, 2012). This aligns with the participant's expectation for EE interventions, that is, learning to identify unhelpful cognitions that contribute towards their EE, and identifying ways of changing EE behaviours.

CBT includes psychoeducation, such as exploring the connection between the mind and the body. In doing so it can support participants in identifying Maladaptive thoughts and encourage replacing such unhelpful thoughts (e.g., *"If I am sad, then I deserve to eat to comfort myself" or "If I am sad or happy, then the only way I can calm down or comfort myself is through eating"*) and behaviours with adaptive coping strategies such as cognitive restructuring or reappraisal. PPIE members favoured a CBT intervention approach, and there is strong support from existing literature for its use for EE among global majority populations. That said, it is important to acknowledge that traditional beliefs linking mental health distress to supernatural forces, such as 'jinn' or 'religious transgressions', as well as

the mind and the body being viewed as one within the Middle Eastern population may pose barrier for the use of CBT with this population. Naeem (2015) proposes that gaining insight into clients' perceptions of mental health challenges and providing psychoeducation are valuable adaptations in navigating these cultural complexities. Al-Ghazāli introduces the concept of the "Therapy of Opposites," aligning behavioural responses with cognitive processes. This concept finds its roots in the integration of thoughts, beliefs, and behaviours, echoing the common Islamic idea expressed in the Qur'an and Hadiths. Verses such as "We send the messengers only to give good news and to warn..." (Al-An'am 6:48) emphasise the importance of faith and righteous deeds in alleviating fears and sorrows. This recurring theme in the Qur'an underscores the notion that positive thoughts, beliefs, and behaviours can profoundly influence emotions, offering a unique perspective that could complement the principles of CBT within this cultural framework (Sabki et al., 2018). Other rationale for using CBT includes:

- CBT in the treatment of EE has been substantiated by research (Jacob et al., 2018).
- CBT has been identified as the foremost culturally adapted therapeutic approach, as evidenced by various studies (Alatiq & Alrshoud, 2018; Berry et al., 2018; Cucchi et al., 2020; Naeem, 2019; Rathod & Degnan, 2018).
- CBT can be administered as a concise intervention, aligning with the recommendations set forth by the National Institute for Health and Care Excellence (NICE) Guidelines in 2018.
- Central to CBT's efficacy is its focus on the present moment and its provision of problem-solving techniques. Such features have proven to be of particular value within non-westernized cultures, as indicated by studies conducted by Naeem et al. (2015). This highlights the cross-cultural applicability and significance of CBT's approach, support by a study conducted by

The intervention for this study is underpinned by Cognitive Behavioural Therapy-Eating Disorder (CBT-E; Fairburn, 2008). CBT-E uses cognitive and behavioural strategies with integrated education to meet the client's eating goals (Fairburn, 2008; Murphy et al., 2010). However, it is essential to note the finding that intervention success with different cultural groups is attributed to interventions incorporating cultural considerations (Alatiq & Alrshoud, 2018; Berry et al., 2018; Naeem, 2019). This means that a solely CBT approach would have dismissed the "first-person" perspective, which is crucial as language in therapy is defined as the primary vehicle of communication, allowing clients to share their history and experiences and express their emotions and personal identity formation (Bonn, 2015; Brown & Altarriba, 2018). Furthermore, from a phenomenological perspective, CBT does not explain the meaning of the individual's experience of psychological difficulties, such as language and cultural barriers (Gallagher & Zahavi, 2020). This means that adjustments to CBT are needed for it to be accessible and effective for non-westernised cultures as highlighted by studies conducted in the UK, Pakistan, China and Iraq (Al-Ghani et al., 2019; Bernal et al., 1995; Hays & Iwamasa, 2006; Cucchi et al., 2020; Naeem et al., 2010). The researcher possesses a substantial experiential background in both individual and group-based administration of CBT, a skillset acknowledged for its advantages by Fairburn (2008). Such experience was likely to be beneficial in helping to account for cultural adjustments to CBT.

Previous research, the findings of phase 1, and PPIE all pointed to the need for CBT be culturally adapted. Specifically, by considering the following factors: spiritual, religious and cultural factors, beliefs about health disorders, and treatment, along with the method of delivery and structure of the intervention. These recommendations were therefore accounted for in developing a culturally adapted intervention to help Middle Eastern women manage their emotional eating. As a result of a collaborative co-construction approach to intervention development, PPIE members felt listened to, particularly regarding their needs and what they

would want to get out of an intervention. Table 3 provides further details on the intervention content and specifies how cultural considerations were accounted for as advised during PPIE.

Table 3: Intervention content

Session number	Intervention Content	Cultural consideration accommodated within the intervention
Session 1	**Objective: Psychoeducation**	
	Task 1) Welcome and introduction to intervention aims and objectives. As well as Address any questions, expectations, or anxieties. *	* Introducing the aim of psychological interventions and offering opportunity to ask questions and raise concerns was intended to help reduce anxiety and ensure participants knew what to expect from the intervention. Expectations from participants, such as being on time and engaging in homework, were also shared. Findings of phase 1, existing literature, and discussions within the PPIE group session all indicate that women in Middle Eastern communities commonly experience anxieties when discussing psychological wellbeing and expressing unpleasant emotion, and so outlining what to expect from the intervention, and providing the opportunity to ask questions was considered important.
	Task 2) Group contract to be discussed and agreed ** This was established in line with Ethical guidelines (BPS, 2018; HCPC, 2020).	** During PPIE, members expressed a preference for group therapy, however anxiety around information being shared outside the group was also discussed. As noted above, expressing emotion, in particular unpleasant feelings, is not considered culturally acceptable among Middle Eastern communities (Lim, 2016; Tahmouresi et al., 2014; Zolezzi et al., 2018). Therefore, setting a group contract and climate establishes a safe space to openly express felt or recalled emotions and the consequences of these. As well as discussing cultural barriers to change, which according to ALgahtani et al. (2019) is vital when culturally adapting CBT.
	Task 3) The modified Dutch Eating Behaviour Questionnaire (DEBQ: Bailly et al., 2012 (Appendix M)) to be completed.	As participants were all from the same city, a group contract agreeing not to share information and experiences outside the group was important to address any anxieties participants may have in sharing unpleasant experiences and difficulties

		with individuals outside their family members. They all used the term 'I put my trust in god that confidentially will be maintained'.
	Task 4) Defining EE and influences on emotional eating. ***	*** During the interviews and PPIE discussions, participants noted that their understanding and awareness of EE had developed since moving to the UK. However, this was still limited. Through PPIE discussion the participants acknowledge the impact of socio-cultural experiences since moving to the UK which had led to unpleasant emotions being managed through EE (Al-Bkerat, 2019; Donnelly et al., 2011). In particular, due to Middle Eastern women's goal of maintaining group harmony (e.g., avoid being judged) and preserving their family honour and name, the suppression and repression of emotions was identified among Middle Eastern women, with a recognised consequence of this being to manage emotions through consumption of food (Wilson & Tyler, 2018). Cultural beliefs about sharing emotions were identified as one of the main barriers for seeking professional support which highlighted the importance of exploring such influences. This was discussed during PPIE with members recommending that it would be beneficial to explore such influences that remained despite living in a westernised culture whereby people are a lot more expressive and open about their emotions and concerns.
	Task 5) CBT psychoeducation on the mind and body connection (the EE cycle). ****	**** Findings from phase (1), and then discussions during PPIE indicated that EE was understood more from a biological perspective, such as a genetic influence or ability to eat more. This is supported by research which indicates that many non-western cultures use a biological and social–spiritual models of illness (Naeem et al., 2016). A desire to learn more about the mind and body connection was expressed during the interview and within the PPIE group discussion, as their knowledge was limited. Such models influence their belief systems, especially

		those related to health, well-being, disease, and help-seeking in times of distress. Prominent clinicians , including Cucchi (2020), Sheik (2018) and Thomas (2013), emphasise the need for alignment between Cognitive Behavioural Therapy (CBT) and Islamic principles. They argue that CBT's core elements, especially its focus on the interconnectedness of thoughts, emotions, and behaviour, as described by Greenberger and Padesky (1995), resonate with Ghazali's (1986) conceptualisation of the human psyche. Ghazali (1986) emphasises the inherent interconnectedness of respective constructs, suggesting that an imbalance in one component carries influence throughout the entire system. Al Bukhari introduces an additional dimension by implying the integration of the physical dimension or "body" within this complex interrelation. Therefore, providing individuals with CBT psychoeducation on the mind and the body connection (EE cycle) and the role of thoughts and beliefs in influencing EE was advocated as important to raise awareness about the EE cycle. Naeem (2018) suggests that it becomes an integral part of the therapy to educate the clients about biopsychosocial causes of illness. With culturally adapted CBT, the emphasis shifts towards reconsidering the helpfulness of thoughts and replacing unhelpful ones with those that contribute positively to the individual's well-being. Hays (2013) suggests that when working with certain cultures challenging the validity or rationality of concerns/worries might be perceived as insensitive or naïve. A more culturally responsive approach would involve listening carefully, sensitively validating fears without reinforcing stereotypes. Once a trusting relationship is established, the therapist can then assist in exploring the helpfulness of those worries. This might entail asking questions like, "If you've taken all necessary actions, are there more positive thoughts you could focus on? For instance, reminding yourself of the strength derived from your faith, culture, and family." Rather than: “What’s the worst that could happen? How likely is this to happen? This has been accounted for in the present research, due to researcher being from a ME background, having worked

		with ME populations, and used interviews and PPIE to ensure a further understanding of the experiences of Middle Eastern women.
	Task 6) Set personalised and specific goals for the management of emotional eating. *****	***** Goal setting: During phase 1 and PPIE the importance of setting personalised goals relative to EE was noted. Setting specific personalised goals forms part of any therapeutic approach but is arguably of particular importance when working with non-westernised clients/participants. This was noted by Kim et al. (2012, p. 42) who suggest that among non-westernised individuals there is a "*need for attaining some type of meaningful gain early in therapy*". Given a lack of experience with and misgivings about a Western style of therapy, perceiving concrete gains in a first session may be particularly important. Another reason for setting personalised goals is based on my experience of working with Middle Eastern women as a training counselling psychologist. I have found that Middle Eastern women often expect to see improvements in every aspect of their life. As such, setting specific individualised goals may help them set realistic expectations, measure any change (small or big), and act as a motivator to adhere to the intervention and continue to apply learned techniques once the intervention has concluded.
	Task 7) Homework: complete a real-time self-monitoring record, which involves recording the behaviours, feelings, emotions and events surrounding food cravings. ******* ***Online resource shared with participants:***	*******Homework (Appendix N). During PPIE discussions, members were asked about their attitude towards homework (tasks set to complete to continue learning, practice, and development at home). Members shared that they were willing to engage with homework, as long as they knew what to expect and the worksheets were easy to understand and short. Research also indicates that homework should be minimal when working with non-westernised individuals (Naeem, 2019). As such, they were introduced to a simple self-monitoring record which involved recording their behaviours, feelings, emotions, and events surrounding food cravings; a tool utilised in CBT-E. This allowed participants to monitor their

	YouTube video titled: “What Is CBT & How Does It Work? In Arabic.” (Retrieved from: https://www.youtube.com/watch?v=4_k5oUJ7ZqA).	feelings, behaviour etc in between sessions. Fairburn (2012) suggests that this is important as it helps the individual observe, question, and modify their thoughts and behaviour. Finally, asking the participant to include physical symptoms in their pack allowed them to see the link between thoughts and physical symptoms associated with emotions. This is particularly useful as non-westernised individuals are more likely to refer to somatic symptoms when referring to unpleasant emotions such as anxiety (Mooney et al., 2016).
Session 2	**Objective: Education and Problem-solving** **Task 1)** Homework is integral to CBT and thus CBT-E. * **Task 2)** Introduction to Maladaptive thoughts and beliefs. **	*Fairburn (2008) proposes that homework is the foundation upon which other changes are built. For example, homework activities can underpin a decrease the frequency of acting on cravings. Therefore, the second session started with reviewing homework. This was undertaken as a group activity, as PPIE members reported that an aim of group therapy should be to normalise struggles in expressing emotions and with EE and facilitate support from other Middle Eastern women. As such, discussing homework provided the opportunity for participants to talk about their struggles. Sharing emotions and experiences through homework can work particularly well as people had time to think about and reflect on their experiences. Research suggests that the benefit of group therapy and sharing experiences can be the provision of a positive support system, increasing the chances of feeling less alone (Ezhumalai et al., 2018). A group approach offers a safe space where individuals can share their difficulties, and this can facilitate a positive shift in attendees' perspective as a result of being exposed to new behaviours, thoughts and beliefs (Malhotra & Baker, 2022). ** Findings from phase one highlighted the influence of Maladaptive thoughts and beliefs on EE, with such thoughts and beliefs heavily influenced by cultural

		beliefs and values. Building on this finding, PPIE members discussed the need to explore cognitions and (Maladaptive) beliefs to help identify emotional trigger/problems leading to EE. The influence of thoughts and beliefs on EE have been evidenced in previous research (e.g., Ghrama, Sorenson, Hayes-Skelton, 2013). When working with individuals from non-westernised cultures, it is important to be mindful of what is classed as Maladaptive thinking. For example, beliefs such as not depending on others, pleasing others, or sacrificing own needs for others (such as family) may be classed as Maladaptive by a non-westernised therapist (Naeem, 2013). This also means that literal translations of CBT terminology may not be helpful. Naeem (2013) recommends that in educating individuals about cognitive errors it may be better to explain the concept (e.g., fortune telling or black and white thinking) followed by asking the individuals how they identify the thinking style in their own language (Alghatani et al., 2019). Furthermore, in order to educate individuals and help them recognise their thoughts, participants can be asked to define thoughts as images, helping to overcome translational problems (Naeem, 2015). Findings from phase one and PPIE also indicate that exploring the role of religion can be beneficial in identifying and addressing misconceptions and Maladaptive thinking (Algahtani et al., 2019). Maladaptive thoughts such as fortunate telling, overgeneralising, and black and white thinking appears commonplace among this population resulting in "if…then" rules for living. During PPIE discussion, members shared that 'if, then' rules for living were common due to pressures from others stemming from cultural etiquettes associated with putting others first. Therefore, identifying Maladaptive thoughts may increase participant's awareness and encourage them to challenge such thoughts, exploring what is meaningful to them (Naeem, 2018). It has been recommended that EE interventions explore cognitive errors and maladaptive thinking utilising religious stories (if applicable

	Task 3) Introduction to Problem-solving. *** **Task 4)** Homework: 1) Practice problem-solving allowing the participant to practise outside the session, become familiar with the process, and learn to continue to practise Problem-solving beyond intervention. 2) The following video was shared with participants as part of homework which explains CBT cycle and Maladaptive thoughts in Arabic language (by Alyaa Gad. Retrieved from: Alyaa Gad - Cognitive Behavioural Therapy (CBT) العلاج المعرفي السلوكي – YouTube: https://www.youtube.com/watch?v=0jziwZGlCF0	and appropriate) when working with Muslim or Christian individuals (Ayub & McGuire, 2013, Sarhandi & Gul, 2014). ***Fairburn (2012) suggests that helping clients solve problems is crucial as it can effectively help them successfully address the event that would otherwise influence their eating. Naeem et al. (2019) suggest that behavioural activation and problem-solving are popular and well-received techniques among non-westernised individuals, including muscle relaxation or other spiritual techniques such as listening to the Quran. Indeed, problem-solving was requested by participants during phase one and PPIE discussion as individuals felt that they could improve problem-solving skills to regulate emotions and thus reduce reliance on food to manage their emotions.
Session 3	**Objective: Problem-solving, managing unhelpful thinking and mood regulation** **Task 1)** Review homework	* Findings from phase 1 indicated that mood acceptance was difficult due to the influence of cultural and religious beliefs which often led participants to repress or

	Task 2) Introduction to thoughts challenge and mood acceptance: education about moods and acting on moods *.	supress emotion. During PPIE, members felt that difficulties in accepting their mood contributed towards EE, and as such felt that mood acceptance was important to cover as part of the intervention. Mood acceptance involves educating individuals about moods as a normal part of human experience, and that by normalising feelings including angry, sad, or unhappy; that they will decrease. It involves learning to identify moods and act on moods (e.g., education on that moods do not need a reaction). As highlighted through research among non-westernised cultures certain emotions such as anxiety are expressed through somatic instead of psychological symptoms (Mooney, Trivedi, & Sharma, 2016). For example, distress is more likely to be conveyed through somatisation, such as nausea or stomach-ache (Melisse, Beurs & Furth, 2020). Education on moods and acceptance can minimise misinterpretation and mislabelling of emotions, which can in turn help with identifying moods and managing these through other helpful means such as acceptance (Fairburn, 2008; Murphy et al., 2010).
	Task 3) Homework: Practice thought challenge and the use of functional mood modulatory behaviour (appendix N). **	**Through practising mood modulation, the participant will be encouraged to come up with useful resources which they could then utilise when needed.

Session 4	**Relapse plan and continuity.** **Task 1)** Review homework **Task 2**) Discuss relapse plan including review strategies learned, identify potential barriers, and discuss maintenance plan and strategies continuity of EE management. **Task 3**) Complete the EE subscale of the Dutch Eating behaviour questionnaire scale (Appendix M) and open questions evaluating participants' intervention experience (Appendix M).	In order to maintain what has been learned, participants will be provided with a summary of the intervention sessions. They will also be provided with a booklet which contains information about EE and a self-help worksheet. Finally, following the cessation of data collection, participants will be given the opportunity to attend a monthly group session in which any challenges associated with intervention content or questions can be discussed. This is in response to the findings of phase 1 and recommendations of PPIE for interventions with Middle Eastern women they individuals should continue to meet so they can continue to support each other.

CHAPTER SEVEN: Phase Two: Piloting a Culturally Adapted Emotional Eating Intervention for Middle Eastern Women

7.1 Introduction

Emotional eating is defined as (over) eating in response to emotions, including depression, stress, and happiness (Frayn et al., 2018; Strein, 2018; VanStrien, 2013), when food consumption is used to regulate emotions (Athena, 2015). EE can lead to an increased calorie intake and weight gain over time (Yau & Potenza, 2013). Research has examined food consumption and EE among various cultures, revealing similarities and differences (Prescott et al., 2002). However, the Mental Health Foundation (2019) has identified a significant gap in research among BAME communities, specifically Middle Eastern cultures, and a need for culturally appropriate interventions for this population has also been identified (Memon et al., 2016). During phase 1, Middle Eastern women identified EE as problematic, but lacked an understanding of EE and had limited knowledge about available interventions and help-seeking options for EE.

When exploring factors perceived as contributing towards EE, cultural factors were identified by Middle Eastern women as influential, as also indicated in previous literature (Cresswell & Plano Clark, 2007; Leersnyder et al., 2015; Siren & Sanlier, 2018). Perera et al. (2020) propose that culture can significantly influence individuals, including their treatment seeking behaviours, with personal and social stigma carrying influence within Middle Eastern culture. Therefore, understanding and considering cultural factors when developing and/or delivering an intervention is of considerable importance (Perera et al., 2020). The benefit of culturally adapted interventions has been highlighted in several meta-analyses reporting a significant positive impact on the outcome of interventions (Degnan et al., 2017; Smith, Rodríguez, Bernal, 2011).

7.2 Aims and Objectives

Having undertaken interviews during phase 1 to explore the experiences of Middle Eastern women with EE, and their recommendations for culturally adapted EE interventions, and then utilising PPIE to support the development and acceptability of a culturally adapted intervention, phase 2 was intended to pilot the resultant intervention and explore participants experienced with it. The culturally adapted EE intervention focused on increasing participants' awareness of EE, identifying triggers for EE, and presenting techniques to help manage triggers and regulate emotions using means other than food.

7.3 Research Questions and Hypothesis

The following research questions were utilised to evaluate a brief intervention intended to help regulate emotional eating:

Research question 1: What were participants' experiences with the brief EE intervention?

Research question 2: To what extent did the intervention meet cultural needs regarding the management of emotional eating?

Hypothesis: The aim of pilot work is not to test hypotheses about the effects of an intervention, but rather, to assess the feasibility and acceptability of an intervention approach. However, a hypothesis is presented that is aligned to the predictions of previous EE research. Specifically, it is hypothesised that the intervention will reduce desire to eat in response to emotions from pre- to post-intervention as compared to a waiting list control group.

7.4 Method

7.4.1 Design

A mixed method design (MMD) was utilised which consisted of quantitative and qualitative approaches. A quantitative approach enabled an evaluation of the efficacy of the intervention.

Specifically, the EE subscale drawn from the modified Dutch Eating Behaviour Questionnaire (DEBQ: Bailly et al., 2012) was completed by all participants to evaluate pre- and post-intervention scores for desire to eat in response to certain emotions. The qualitative approach used an open-ended questionnaire to explore participant's experiences with the intervention and the extent to which the intervention was perceived as meeting their cultural needs. The benefit of using MMD are detailed in the method section of phase 1, but in essence a quantitative approach supports an examination of intervention efficacy in reducing EE, whilst a qualitative approach supports an evaluation of feasibility, acceptability, process, and outcomes of the phases of the intervention, thereby providing valuable extended data on quantitative findings (Klaice et al., 2022; Sidani, 2016).

7.4.2 Participants

Inclusion criteria for the present study included being a Middle Eastern female residing in the UK, age 18+, who wished to reduce emotional eating, it was also noted that participants must be able to speak English. This is because individuals from Middle Eastern speak different languages and so the intervention would be delivered using English language as a common language. Regarding exclusion criteria, participants with a suspected or diagnosed eating disorder were excluded as this requires a different approach to treatment and intervention.

A total of 31 participants identified a desire to address EE as a perceived problem (see Table 5) of which 26 were recruited via online platforms and 5 via snowball sampling. A total of 29 participants met inclusion criteria; however, 23 participants were included in this study. Two participants agreed to take part but did not attend, two participants only attended the first session and were unable to continue due to unforeseen physical health complication, and two were excluded due limited knowledge of and ability to use English language. Of the

23 participants taking part in the pilot study, ten were randomly allocated to a waiting list control group for comparative purposes.

Participant demographics are presented in Table 4. The Middle Eastern women in the intervention group had lived in the UK between 4-17 years (M=10.3, SD=3.3), and their ages ranged between 28 to 45 years old (M=36.8, SD=5.1). Control group participants had lived in the UK between 2-14 years (M=8.2, SD=3.5) and their age ranged between 25 and 48 (M=34.9, SD=7.5). All participants spoke English and all self-selected culturally appropriate pseudonyms for use in writing up this research, and it is these that are presented below.

Table 4: Participant Demographics

	Name	**Age**	**Ethnicity**	**Occupation and marital status**	**Year of UK residency**	**Children**
Intervention group	**Ahlam**	33	Afghanistan/Syria	Housewife/Divorced	12	Three
	Suhaila	42	Iran	Housewife/Married	7	Three
	Shams	28	Iraq	Student/Married	13	Three
	Samar	45	Kurdish	Housewife/Married	9	Two
	Suzan	37	Lebanon	Housewife/Married	11	None
	Namo	27	Egypt	Volunteer/Married	10	Two
	Mariam	33	Syria	Activity-Co/Married	14	Three
	Rula	36	Afghanistan/Iraqi	Carer/Married	17	Two
	Sameera	40	Iraq	Housewife/Married	6	Three
	Heba	42	Kurdish	Housewife/Married	9	One
	Noa	40	Iraq	Housewife/Married	12	Three

	Qamar	39	Yemen	Housewife/Married	10	Three
	Neelam	37	Turkey	Housewife/Married	4	Four
Control group	**Shawbo**	31	Kurdish	Housewife/Single	2	Four
	Shna	41	Iraq	Housewife/Married	6	One
	Mayada	32	Yemen	Housewife/Married	9	None
	Noor	45	Syria	Housewife/Married	7	Three
	Aysha	29	Afghanistan/Saudi	Housewife/Married	11	Three
	Meltam	31	Turkish	Housewife/Single	14	Five
	Mariam	25	Turkish	Housewife/Married	13	Two
	Hannan	27	Palestine	Housewife/Single	8	Two
	Amelia	40	Saudi	Housewife/Married	8	Three
	Nagam	48	Iraq	Housewife/Single	4	Five

7.4.3 Measures

The modified Dutch Eating Behaviour Questionnaire (DEBQ; Bailly et al., 2012)

The modified DEBQ scale (Bailly et al., 2012) was used in the present study, which consists of six items measuring emotional eating. Specifically, these items were:

- Do you have the desire to eat when irritated?
- Do you have the desire to eat when something unpleasant is about to happen?
- Do you have desire to eat when feeling lonely?
- Do you have desire to eat when depressed or discouraged?
- Do you have the desire to eat when things go wrong?
- Do you have the desire to eat when emotionally upset?

All items had a five-point response format; never (1); seldom (2); sometimes (3); often (4); and very often (5). One total mean score was utilised for scoring. The mean scores were obtained by dividing the sum of the items scored by the total six items. In terms of validity

and reliability of this measure, all versions of the DEBQ have reported good factorial validity and reliability as well as satisfactory internal constancy (Baily et al., 2012). The Cronbach's alpha value for the modified DEBQ scale (Bailly et al., 2012) was .90 for emotional eating, indicating satisfactory internal consistencies. Intervention and waiting list control group participants all completed this measure at both the pre- and post-intervention assessment points.

Bespoke Pre- and Post-intervention Questions

Bespoke pre- and post-intervention questions were completed by intervention group participants only. Responses to questions were offered on a 5-point Likert scale (0 = not at all 5 = a lot). The pre-intervention questions were intended to measure motivation and confidence to change their EE. Specifically, **'**How motivated are you to change your emotional eating?' and 'How confident are you that you can change your emotional eating?' The post-intervention questions were intended to measure confidence relative to EE, specifically 'How confident are you that your EE has changed?' and 'How confident are you that you can maintain changes to your emotional eating?'. These questions were of value as previous research has found a positive associated between high motivation to change and several desirable clinical indices such as adherence, decrease in eating pathology, and overall outcome of the intervention; all of which are important for intervention efficacy (Hoetzel et al., 2013). The rationale for measuring confidence to change and confidence in maintaining change was due to research suggesting that confidence can offer insight into an individual's commitment to taking on new challenges and overcoming barriers (DeCorby-Watson et al., 2018), both of which may influence intervention efficacy.

Intervention experience questionnaire

To explore the participant's experience with the pilot intervention and its perceived cultural relevance, intervention group participants were asked to answer eight questions at the end of week four (Appendix M). These questions were:

- Now you have completed all four workshops, what has your overall experience of them been?
- Were some aspects more helpful than others? If so, what did you find most helpful and why?
- What if any aspect did you find less helpful or more challenging?
- Did you find it easy to understand the workshop and homework content?
- To what extent did the workshops and homework accommodate your cultural and religious needs?
- What would you like to have seen more of?
- What changes, if any, have you noticed as a result of taking part in these workshops?
- Do you feel that you understand your EE better? If so how?

This open-ended questionnaire was set up on Google Forms. Participants were emailed a link to the questionnaire and instructed to complete it at the end of session four. Whilst participants were asked to complete this questionnaire via a google form, they preferred to send responses via email. All the thirteen participants completed all eight questions.

7.4.4 Intervention overview

An intervention overview is provided in Table 5 to detail the content of each of the four weekly group sessions and associated homework activities. This is then described in further detail within the procedure section.

Table 5: Summary of Intervention content.

Sessions	Content	Homework
Session 1	**Aims: Psychoeducation** • Welcome and introduction to the intervention and group contract. • Complete the adapted EE scale (Bailly et al., 2012; Appendix M) and two questions measuring motivation and confidence to change EE. • Psychoeducation. • Goal setting	1) To reflect on the CBT cycle discussed. 2) To complete the thought record
Session 2	**Aims: Education and problem-solving** • Review homework. • Discuss Maladaptive thoughts and beliefs. • Introduction to problem-solving.	1) Complete the problem-solving worksheet.
Session 3	**Aims: Managing unhelpful thinking and mood regulation** • Review homework. • Introduction to cognitive restructuring. • Mood acceptance.	1) Complete the cognitive restructuring worksheet.
Session 4	**Aims: Relapse plan and continuity** • Review homework. • Discuss relapse plan including review strategies learned, identify potential barriers, discuss maintenance plan and strategies for ongoing EE management. • Complete 1) the adapted EE scale (Bailly et al., 2012), 2) two bespoken questions measuring confidence about changes occurring and confidence to maintain changes to EE, and 3) open questions evaluating participants' intervention experience (Appendix M).	1) To complete the intervention evaluation questions.

7.4.5 Procedure

Ethical approval was obtained from the University of Wolverhampton before collecting data (Appendix I). Participants were then recruited through Twitter, Facebook, community centres, visiting community centres (handing out posters) and snowball sampling. A recruitment poster consists of information of the pilot study, inclusion and exclusion criteria was used

(Appendix) Participants were given to option to contact the researcher either by email or via Facebook messenger.

Participants who showed interest were provided with a project information sheet and consent form via email, Facebook, or face-to-face. This practice complied with the British Psychological Society's Code of Ethics and Conduct (2009) (see Appendix K & I). The project information sheet provided information about the nature of the intervention, what would be expected of participants, and provided the opportunity to request any additional information regarding the study or potential involvement. Those interested in taking part were screened for suitability against the inclusion and exclusion criteria and in meeting inclusion criteria were given information about the venue and time the intervention started. Informed consent was obtained from all participants (intervention and waiting list control) via email prior the start of the intervention.

The four weekly intervention sessions were conducted face-to-face as a group and delivered in a Middle Eastern community centre. Each session was scheduled for approximately 3 hours to allow group discussion and interaction regarding each session's focus. Each group session was supplemented by self-help booklets that reinforced the key messages for each session (see Appendix N).

During the first session, participants were first reminded of the purpose and structure of the intervention. Then, were allowed to ask any questions. The next step involved discussing a group contract in which they agreed on principles of confidentiality, maintaining contact outside the sessions, and house rules such as being on time for sessions, not using phone etc during the sessions. They were advised only to share information they felt comfortable sharing during the sessions and that they could stop at any time in the event of becoming distressed. They were also provided with the researcher's email if they had any

questions or concerns outside the sessions, and with their consent a WhatsApp group was created where they could ask questions outside of sessions.

Once the group contract was agreed, participants were asked to complete the modified Dutch Eating Behaviour Questionnaire (DEBQ; Bailly et al., 2012; Appendix M) and pre-intervention questions. Following this, as indicated in Table 5, participants were provided with psychoeducation about EE, including an examination of Head hunger and Physical Hunger. Session two started with reviewing and discussing outcomes of the thought record homework task. This was followed by introducing Maladaptive thoughts and exploring problem-solving techniques. During session 3 homework on Maladaptive thoughts and Problem-solving task was reviewed followed by introducing to though record and function of moods and moods acceptance. In the fourth and final session, homework on cognitive restructuring was reviewed, followed by completion of a relapse prevention plan which was intended to recap and review techniques learned, identify potential barriers, explore maintenance plan and strategies for ongoing EE management. Finally, the adapted EE scale, two bespoke questions measuring confidence (about changes made following the intervention and confidence of maintaining changes), as well as open questions evaluating participants' intervention experience were completed.

The control group were informed that they were on a waiting list for the EE intervention and would be contacted when the second iteration of delivery was planned. They all indicated a willingness to wait and provided informed consent to complete the modified Dutch Eating Behaviour Questionnaire (Bailly et al., 2012) on two occasions, four weeks apart (mirroring the completion schedule of intervention group participants).

7.4.6 Data analysis

To test whether the desire to emotional eat had reduced in the intervention group compared with a control group over the same time period a repeated measured ANOVA was performed using SPSS (V26)**.** This means that repeated measures ANOVA was performed with means of the modified subscale scores of the DBEQ (Bailly et al., 2012) as the dependent variable, using full factorial design with intervention and control group as the between-subject factor, and pre- and post-intervention period as the within-subject factor.

Qualitative data attained from open ended questions examining intervention experiences were analysed using thematic analysis (TA; Braun & Clarke, 2006). An inductive approach was adopted due to the exploratory nature of this work (Greaves, 2014). This approach would help ensure that the themes identified closely reflected the experiences and meaning of the participants (Greaves, 2014) having taken part in the intervention. The aim was to establish a greater insight into participant experiences with the culturally adapted intervention and utilise findings to inform future intervention delivery.

7.4.7 Ethical considerations

This project strictly adhered to the ethical guidelines outlined by the Health and Care Professions Council's Standards of Conduct, Performance and Ethics (HCPC, 2016) and the British Psychological Society Code of Human Research Ethics (BPS, 2018). Individuals interested in taking part received project information, and consent forms via email before the intervention. They were also provided with contact details should they have any further questions. A group contract was established during the initial session to discuss confidentiality and session etiquette, and participants were given the option to withdraw at this point.

To minimise the potential for participant distress or harm, a portion of each session was dedicated to grounding exercises aimed at helping participants transition from negative to positive thoughts. To maintain confidentiality, participants chose culturally suitable pseudonyms for use in any quoted material used in write-up and any subsequent publications. Ethical considerations also encompassed the secure handling of data. Pre- and post-questionnaires were disposed of via a shredder following data entry into SPSS. Participant contact details and interview materials were stored separately on a password-protected and encrypted computer system.

7.5 Results and Discussion

The aim of phase two was to deliver a culturally adapted EE intervention intended to enhance participants' awareness of EE, identify triggers for EE, and provide adaptive techniques to manage emotions using means other than food. All thirteen participants attended all four group sessions. Indeed, their motivation for change was evident as they engaged well with all activities, including discussions, homework tasks, and supporting each other in sessions. Those participants who shared contact details with each other also offered support for each other outside the sessions when completing homework.

7.5.1 Quantitative findings

Descriptive statistics are presented in Table 7. Data indicate that the intervention group showed a decrease in desire to eat in response to emotions from pre-intervention (3.93 (*SD*=0.92)) to post-intervention (2.30 (*SD*=0.86)). By contrast, the waiting list control group showed very little change from pre- to post-intervention (pre-intervention 4.20 (*SD*=0.80); post-intervention 4.15 (*SD*=0.89).

Table 7: Descriptive Statistics

Groups	Pre scores for intervention group (*n* = 13)	Post scores for intervention group *(n* =13)	Pre scores for control group (*n* = 10)	Post scores for control group (*n* = 10)
Mean scores	3.93	2.30	4.20	4.15
SD scores	0.92	0.86	0.80	0.89

A repeated measured ANOVA was performed using SPSS (V26), to explore if changes in the desire to eat in response to emotions from pre- to post-intervention for intervention group were statistically significant. There were two independent variables: group (between subjects on two levels; intervention, control) and time (within-subjects on two levels, pre- and post-intervention), and one outcome variable calculated as a mean score using the 6 items derived from the modified DEBQ (Bailly et al., 2012).

The main effect of the group was significant ($F1,21 = 8.92$, $p = .007$, $\eta^2 = .298$). The waiting list control group scored higher (desire to eat in response to emotions) compared to the intervention group. The main effect of time was significant ($F1,21 = 55.61$, $p < .001$, $\eta^2 = .726$). The pre-scores were higher (desire to eat in response to emotions) compared to post-scores. The interaction effect was significant ($F1, 21 = 49.18$, $p < .001$ $\eta^2 = .701$). Specifically, the change between pre- and post-scores were different between the intervention and control group. These differences are illustrated in an interaction plot shown in Figure 7. Together these results confirm the observed trend that individuals who took part in the intervention self-reported a lower desire to eat in response to emotions post intervention when compared to the waiting list control group who did not partake in the intervention.

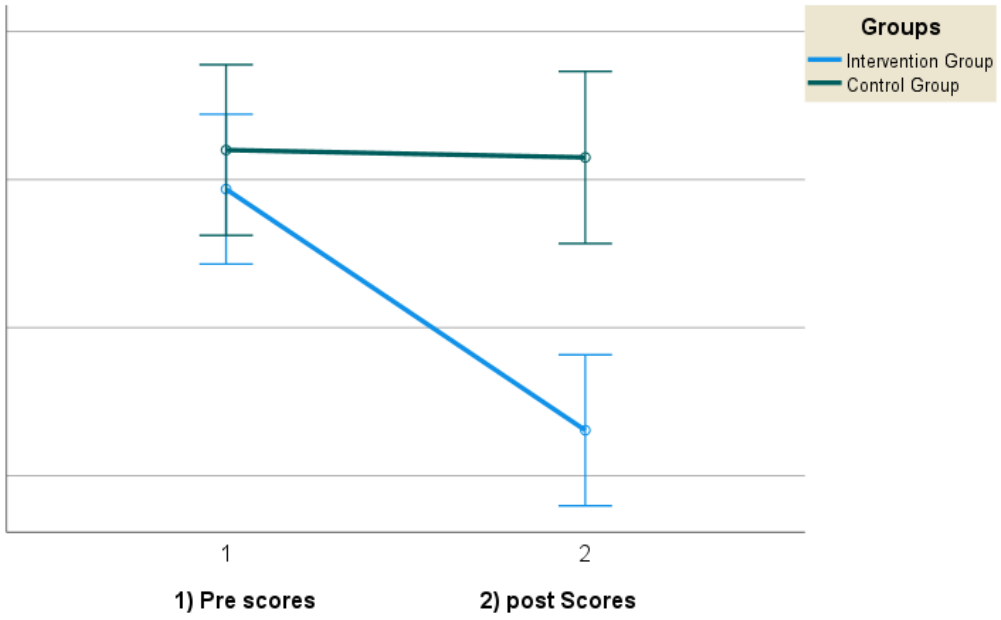

Figure 7: Interaction plot of EE scores for intervention and control group pre- and post-intervention

Findings offer support for the hypothesis that the intervention would reduce emotionally elicited eating for intervention participants from pre- to post-intervention as compared to a waiting list control group. This adds to a growing body of evidence suggesting that brief CBT can be utilised effectively with individuals from collectivist cultures (Jacob et al., 2018; Naeem, 2019; Husain et al., 2020) and non-westernised cultures (Graham et al., 2013; Farooq, 2015), and specifically in managing EE (DJankowska, 2019; Okazaki & Matsumi, 2010).

As shown in Table 8, participants from the intervention group responded to four additional questions examining motivation and confidence relative to the EE intervention. Findings indicate that pre-intervention participants felt highly motivated to change their EE but felt less confident about being able to do so. Post-intervention participants self-reported as confident that their eating in response to emotions had changed, and that they felt able to maintain these changes.

Table 8: Means (SD) for intervention group.

Questions	N	Mean	St. Deviation
1. How motivated are you to change your emotional eating.	13	4.61	.65
2. How confident are you that you can change your emotional eating?	13	2.84	1.95
3. How confident are you that your EE has changed?	13	4.46	.51
4. How confident are you that you can maintain changes to your emotional eating?	13	4.38	.50

Note question 1 and 2 were asked pre-intervention and question 3 and 4 post-intervention.

Motivation for change is an important consideration in delivering psychological interventions (Katrin et al., 2013). As this was high for participants, this may have contributed toward the successful/intended outcomes of the intervention, in that eating in response to emotions significantly reduced for the intervention group (Hoetzel et al., 2013). Research undertaken among non-westernised cultures indicates that this population finds help seeking to be challenging on the grounds of socio-cultural norms for help seeking outside of the family or religious advisors (Dardas & Simmons, 2015; Krstanoska-Blazeska et al., 2021). However, the findings from this study highlighted that non-westernised individuals are motivated to change, which is an important factor for consideration when delivering health-related interventions (Hoetzel et al., 2013), as supported by the significant changes evidence following the present intervention. The findings suggest that helping individuals to identify motivation for change is of value in facilitating support-seeking behaviours and adherence to intervention among individuals generally, but perhaps especially among non-westernised individuals in consideration of cultural influences.

Following the success of this intervention, participants were encouraged to identify opportunities to include, share materials with, and maintain regular contact with relevant cultural supports groups such as the imam or community centres, in order to support others

wishing to better manage EE or indeed overcome concerns about help seeking. It is suggested that this strategy to facilitate support seeking among others was suitable, because post-intervention, participants self-reported as confident about being able to maintain changes. Sharing positive help-seeking experiences with other Middle Eastern individuals may support future help-seeking and help reduce stigma around help-seeking.

7.5.2 Phase 2: Qualitative findings

Following inductive coding, three higher-order themes were identified as follows; 1) *'What worked well'* (comprising four subthemes: 'increased awareness', 'method of delivery' 'Workshop content', and 'Cultural competency'), 2) '*Challenging aspect of the intervention'* (comprising two subthemes: 'intervention challenges' and 'emotional challenges'), and 3) *'Future intervention recommendations'* (comprising two subthemes: 'frequency of sessions' and 'future intervention focus').

7.5.2.1 Theme 1: What worked well?

This theme presents participant's experiences of what worked well and what they liked about the intervention and comprised of four subthemes (see Figure 8). All participants (N = 13) perceived the intervention to be both beneficial and pleasurable. Heba noted: "*my experience was great, because it helped me to think about EE"* whilst Ahlam said, *"my experience has been good because I have seen new perspective of the lives of other women and their stories. It has made me feel normal"*. The act of sharing experiences and/or being exposed to the experiences of other women seems to have fostered a sense of normalcy and established a connection with one's own experiences. This highlights the benefits of creating a therapeutic environment that encourages open sharing and mutual support, as it can contribute to the participants' sense of normalisation and connection within the group therapy setting and the

outcome of therapy. This observation is consistent with prior research and highlights the benefits often associated with group therapy (Erden, 2015; Yosup et al., 2020).

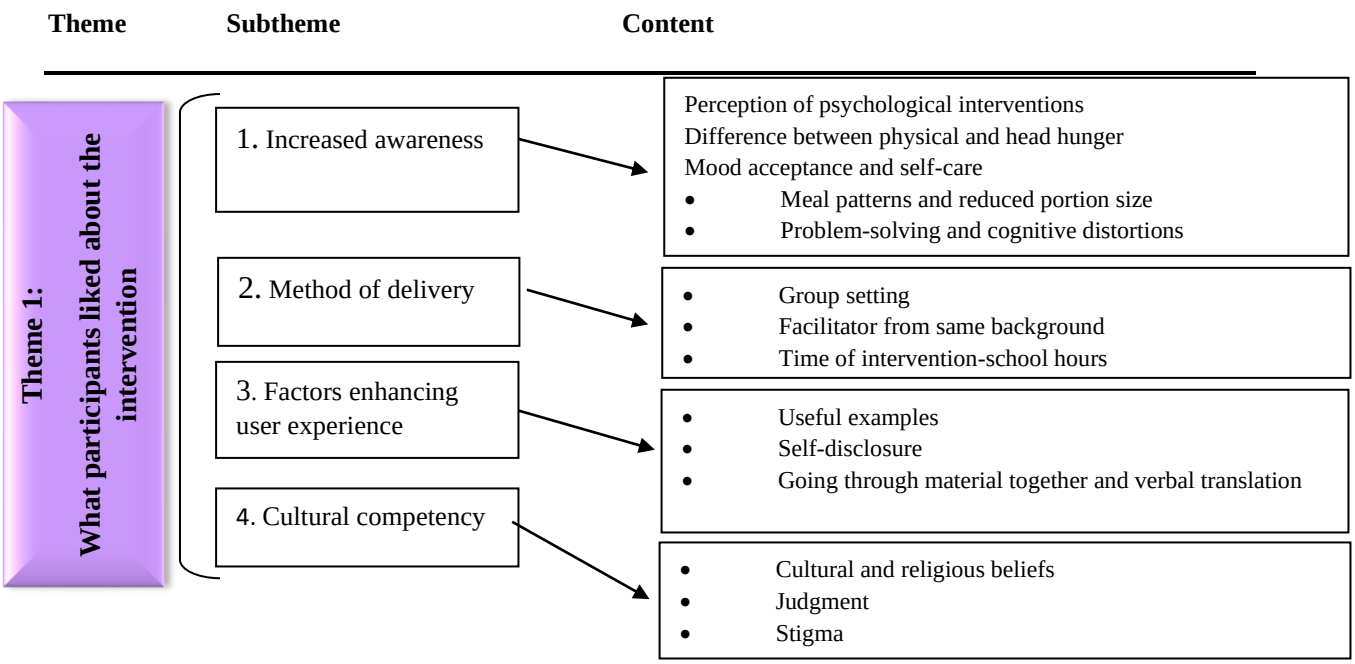

Figure 8: Theme 1 - What participants liked about the intervention

7.5.2.1a Increased awareness

Participants described a heightened awareness of a range of considerations, including the interconnectedness of mind and body, the significance of self-care, a deepened comprehension of the influence of maladaptive thought patterns, and the effectiveness of problem-solving techniques. Notably, most participants (*n* =11) lacked prior experience of psychological interventions, aligning with earlier research undertaken with non-westernized populations (Khan, 2017; Mental health statistics, 2014; Memon et al., 2016). All participants perceived their participation in the culturally tailored EE intervention as producing valued outcomes. For example, Suzan remarked, "*I wish I had encountered this earlier. The psychology workshops offered more than I was expecting in terms of learning".*

The intervention raised participants' awareness of the relationship between the mind, body, and emotions that trigger EE. In terms of increased awareness, consistent with previous

research, participants derived benefit from psychoeducation regarding emotions as triggers for food consumption, impulse control, and reward-motivated eating (Armitage, 2015; Lattimore, 2020). For instance, Suhaila noted *"I really understood my stressful situations and that I distract myself through eating. I am trying to understand now that this is not what I really need* [sweet foods], *and that I can use different things to cope*". Similarly, Namo identified a need to: "*think what is behind/causing my feeling before eating".* Participants gained insight into EE as a compensatory response to unmet psychological needs, aligning with existing research (Devonport et al., 2019; Evers et al., 2018). This appeared to encourage them to eat mindfully and thus check-in using the "'physical' or 'head' hunger technique before responding to emotions through eating. Mariam noted: "*I learned the difference between head hunger and physical hunger, and I use this*". Muna stated: "*the part about controlling intention* [referring to physical and head hunger] *and how to feel was helpful to me*".

Participants felt prompted to introspect before eating, which they perceived as reducing their hedonic eating (Lutter & Nestler, 2009). Bruch (1973) suggests EE emerges from confusing emotional cues with hunger, rooted in early experiences. Fostering self-awareness via techniques such as thought records and CBT cycles yielded positive effects. This is crucial as Kaplan and Kaplan (1973) propose that eating often stems from misinterpreting emotions as hunger. For example, Suzan shared: *"For me, it would be paying more attention to why I eat; I asked myself am I hungry or is it my emotions"*. Shams noted: "*quite a few changes, such as thinking before grabbing food. Be mindful about when feeling overwhelmed and write it down and think about alternative options*". Self-awareness, reflection, and self-acceptance were effective in preventing EE by fostering mood acceptance through acknowledgment of one's emotional state and consequently mitigate emotional eating. Neelam's perspective echoes this notion: *"I've observed that I treat myself more*

compassionately; I refrain from using food as a punishment". Fairburn (2012) proposes that discussing the functions of emotions and mood acceptance can minimise misinterpretation and mislabelling of emotions. This approach aids individuals in recognising their emotional states and responding in different ways, including the practice of acceptance. Kivity and Huppert (2018) demonstrated that teaching individuals to accept and label their emotions accurately improved their emotion regulation skills, reducing the likelihood of relying on maladaptive coping mechanisms such as emotional eating. From a counselling psychology and therapy perspective, these findings emphasise the significance of incorporating emotion-focused interventions into therapeutic practices (Fairburn, 2012). By helping individuals understand the functions of their emotions and promoting acceptance, therapists can contribute to improved emotional regulation and reduce the reliance on unhealthy coping mechanisms. This aligns with the broader goal of enhancing emotional well-being and fostering adaptive coping strategies within the therapeutic context (Kivity & Huppert, 2018). Sabki et al. (2018) recommended incorporating a focus on the meaning of benefits or changes, exploring spiritual factors like the influence on the client's relationship with God, and considering how the client envisions relating to God in the presence of both positive and negative experiences. Additionally, emphasising benefit finding was highlighted as a valuable approach when working with Muslim clients.

Following participation in the intervention, participants reported employing alternative emotional regulation methods eschewing suppression and repression perceived as positively influencing their mood (Ferrer et al., 2017; Kobylińska & Kusev, 2019; Racine et al., 2019; Sultson & Akkermann, 2019). Techniques such as setting daily goals, practicing self-care, engaging in distraction activities, discussing emotions with others, and problem-solving were covered in the intervention and yielded perceived benefits. Samar noted: *"Talking about my emotions to others I found helpful*". Similarly, Neelam noted: "*I have*

found the cognitive distortion very helpful as it enabled me to be more mindful and positive". Suzan noted: *"Self-care I have started daily walking when kids go to school*". Nina shared: *"I have created more activity for myself so that I do not focus on food as often*". The change in their routine enhanced their management of EE through the use of different techniques learned during the intervention. Indeed, some participants prioritised self-care over household tasks during school hours. Research highlights that distraction and alternative activities boost self-control (Gross & Thompson, 2007), helping to avoid food-related temptations.

Overall, participants reported changes in their meal patterns and reduced portion sizes. This was linked to reduce emotional eating but was also influenced by changing behaviours around expectations of eating with children, partner, and visitors. According to Fairburn (2012), it is essential for individuals to addressing eating patterns where they contribute to overeating. Muna noted: *"I saw benefit for me; the most important part, in my opinion, was to eat three meals and two snacks daily and talk about emotions*". Adjustments in meal habits, including reduced portion sizes, reduced consumption of sweets, and adherence to recommended meals and snacks, were deemed successful. Namo affirmed, "*I have been able to reduce my portion size and sweet intake when feeling upset/sad*". Muna stated: *"I am more aware* [of what and when I eat] *and have regular meals and snacks*". Reductions in portion sizes and the adoption of regular meal and snack routines proved helpful for participants, a finding aligning with previous research (Fairburn, 2002).

All participants felt they acquired useful knowledge from the intervention, with learning in respect of cognitive distortion and problem-solving particularly valued by participants. Ahlam noted: "*It was most helpful. I used the action plan* [referring to problem-solving] *and cognitive distortion"*. Noa shared: "*I found the cognitive distortion very helpful as it enabled me to be more mindful and positive".* Suzan noted "*I have found problem-solving useful; I can see how writing about my issues can help me think more clearly about*

alternative options…but it didn't feel like this before the problem-solving workshop”. Similarly, Nina notes: "*The Q and A aspect* [referring to problem-solving] *of the workshop was very helpful because it wrote my thoughts out on paper and that was a relief*".

Findings indicates that the problem-solving and cognitive distortion activities encouraged self-reflection and the identification of different solutions thereby offering relief. Many participants reported realising that they often engaged in maladaptive thinking. Neelam noted: “*I remember the black and white* [referring to Maladaptive thoughts] *and only seeing one negative thing and not the positive thing*". Being aware of maladaptive thinking and cognitive distortions was perceived as helpful in managing emotions in ways other than using food. These findings indicate that incorporating problem-solving and cognitive distortion activities into therapeutic interventions was helpful in enhancing coping and emotional well-being (Beck, 1979). The emphasis on self-reflection and the identification of various solutions contributed to emotional relief for participants. The awareness of maladaptive thinking and cognitive distortions, as highlighted by Neelam's experience, proved valuable in promoting emotional regulation and identifying alternative strategies for managing emotions beyond resorting to food.

7.5.2.1b Method of delivery

The group-based nature of the intervention was positively regarded by all participants. The effectiveness of group therapy as compared to individual therapy was supported through a systematic review of obese individuals (Paul-Ebhohimhen & Avenell, 2009). Neelam noted *"I really, really enjoyed, and I wish we can do more of this. Because talking to other women and someone who can help us and has the knowledge makes it so much valuable*". Qamar also noted "*my experience has been good because I have seen a new perspective of the live(s) of other women and their stories. It has made me feel normal*", whilst Samar noted *"talking*

about my emotions to others I found helpful". Sharing their experiences with fellow Middle Eastern females seemingly had a positive impact, providing a sense of understanding and relief that their experiences were not unique. In contrast to research suggesting that individuals from non-westernized cultures are reluctant to share negative experiences, every participant in this study benefited from sharing (their own or others sharing).

The practice of group contracts and discussions regarding confidentiality, as advocated by Prinyapol and Chongruksa (2013), played a pivotal role in creating an atmosphere of trust and cohesion. This strategy aligns with the principles of creating a supportive environment for addressing difficulties and fostering effective group dynamics (Prinyapol & Chongruksa, 2013). Yosup et al. (2020) conducted a systematic review assessing the effectiveness of counselling group therapy and reported positive findings among non-westernized cultures. Their research emphasises the significance of factors such as social support, shared goals, self-awareness, and trust in the efficacy of group therapy. Initiating the therapeutic process by attending to introductions, group contracts, and ethical principles is important for building trust within the group (Erden, 2015; Yosup et al., 2020). In the present study, establishing trust and cohesion through group contracts and discussions about confidentiality helped create a safe space for individuals to openly share their experiences. Focusing on shared goals and self-awareness was also deemed by participants to be an effective therapeutic strategy relative to EE.

Another important consideration noted by participants was the significance of the therapeutic alliance. Namo's statement, "*I feel understood because* [names researcher] *understands the culture,"* offers insight into the value of having a therapist with a shared background in fostering a sense of understanding and comfort. This aligns with previous research noting that therapeutic relationships can be enhanced when therapists share cultural background (Degnan et al., 2017; Khan et al., 2019). From a therapeutic alliance perspective,

cultural congruence in therapist-client relationships is an important consideration. However, where this is not possible, tailoring therapy to align with the client's cultural background can contribute to a stronger therapeutic alliance, fostering a deeper sense of understanding and connection (Khan et al., 2019). This, in turn, may positively influence the overall effectiveness of therapeutic interventions.

Delivering the intervention during school hours was perceived to be beneficial. Qamar noted "*It was good timing as the children were in school and I could focus.*" This sentiment was echoed by most participants who described facing challenges engaging in activities outside of school hours due to family responsibilities. Scheduling sessions during school hours allowed them to fully engage in the intervention. This has previously been noted by Khan et al. (2019) who found that interventions delivered during school time increased interest and reduced dropout rates among non-westernized mothers. These findings emphasise the importance of addressing such considerations when working with minority groups.

7.5.2.1c Factors enhancing participants experience

Participants perceived the intervention content to be comprehensive and user-friendly. Several factors contributed to this positive experience, including collectively navigating the material, utilisation of illustrative examples, therapist self-disclosure, the availability of therapist contact, and the option for Arabic translation/interpretation during sessions. Such benefits are noted in the following illustrative quotes; "*the workshop was understandable, beneficial, and well-prepared. Its content is so useful and to the point*" (Suhaila), "*it was all very clear, and it was nice for the other ladies to translate some English words into Arabic*." (Suzan), and *"it was easy to understand because I could ask in Arabic to other women, and we all helped each other*" (Neelam). This highlights the significance of communal support

and knowledge sharing in augmenting their grasp of the intervention's content. These findings also support previous research highlighting the advantages of utilising group approaches, such as benefits of interpersonal feedback, emotional sharing, and cohesive group dynamics (Burlingame et al., 2013; Grenor et al., 2017). These findings emphasise the importance of tailoring interventions to be culturally sensitive, user-friendly, and inclusive. Attending to communal support mechanisms and language accessibility can enhance engagement and understanding among participants. Therapists may benefit from adopting similar strategies in group settings, acknowledging the positive impact of interpersonal dynamics, emotional sharing, and cohesive group interactions (Burlingame et al., 2013; Grenor et al., 2017).

The structured approach of reviewing homework tasks at the session's conclusion, coupled with additional instructions provided in their workbooks, supported the ease of completion of homework assignments. The participants' ability to engage with the therapist for clarifications also played a pivotal role in this regard. As Shams pointed out, "*it was easy to understand because it explained what we had to do, and we could always* text [names researcher] *if we had forgotten*." The efficacy of simplified and specific homework tasks, coupled with therapist support, has been affirmed when working with non-Westernized individuals (Naeem, 2019).

In summary, the participants' positive experience with comprehending the intervention's content can be attributed to a multifaceted approach involving group interaction, illustrative examples, therapist engagement, and language support. This echoes the positive outcomes indicated in relevant research on group interventions. These findings underline the value of culturally sensitive strategies in fostering participant engagement and understanding within interventions.

7.5.2.1d Cultural and religious influences

Participants felt that cultural and religious influences were effectively considered throughout the intervention sessions. Reflecting on cultural and religious causes of unpleasant emotions was reported to be particularly beneficial. For example, stigma, adherence to cultural etiquette, and the influence of religious beliefs and values were perceived as tied to a collectivist culture, which emphasises the community over the individual. Such influences were discussed as advocated in existing research (Al-Qarni, 2019). Neelam reflected:

> *I do not know why I always thought that Allah wants me to be happy all the time, but this is not true because the other women were talking about how we are allowed to feel angry and sad in our religion, but culture don't let me I think.*

This highlights how participants can internalise a belief that their religious principles mandate constant happiness, leading to conflicting emotions when experiencing unpleasant feelings. This can hinder the expression of unpleasant emotions. Religious myths, frequently reported in mental health research, were connected to a lack of faith and the misconception of being punished for sins (Dardas & Simmons, 2015; Kingdon et al., 2010; Krstanoska-Blazeska et al., 2021). Religious factors were integrated into intervention discussions, with participants sharing verses from the Quran and hadith (sayings from Prophet Mohammed) that emphasised sharing difficulties with Allah, maintaining a positive outlook, and practicing self-compassion and kindness. The incorporation of religious coping methods has been acknowledged as effective (Degnan et al., 2017) and was the case in the present intervention. Post-intervention, participants felt more empowered to express unpleasant emotions potentially leading to positive outcomes. This finding echoes the success of previous culturally adapted interventions delivered within non-Westernized cultures (Degnan et al., 2017; Smith et al., 2011).

The integration of religious factors, including Quranic verses and hadiths, into the intervention aligns with the principles of Islamic integrated CBT. Participants can be encouraged to draw upon religious coping methods, such as sharing difficulties with Allah, maintaining a positive outlook, and practicing self-compassion and kindness. This supports the integration of Islamic teachings with cognitive-behavioural principles and can provide a culturally sensitive and effective approach to addressing mental health concerns with Muslim populations (Haque & Riaz, 2018).

Participants found culturally embedded maladaptive thoughts and beliefs to be significant contributors in their experience of emotion and EE. Notions like the evil eye, superstitions around black cats, or the belief in perpetual misfortune often led to stress, anxiety, and a constant state of alertness, prompting them to seek solace in EE. Shams aptly expressed the transformative influence of this realisation: "*I realised how much my beliefs and thoughts were shaped by culture and parents. It has made me reflect on the fact that I am in control now and that I need to start thinking about myself*." Such insights illustrate the potential role of cultural upbringing in shaping behaviours and attitudes, with such realisation prompting some individuals to take control and initiate positive change. The acknowledgment of superstitions and beliefs, such as the evil eye or perceptions of perpetual misfortune, were identified as cultural beliefs that could influence mental well-being. By helping individuals recognise and challenge these thoughts, therapists can empower clients to take control of their thoughts and initiate positive changes in their emotional experiences.

A further cultural factor perceived as influencing EE was the worthiness of hospitality being evaluated through food offerings (Stephenson & Ali, 2018). This observation aligns with literature on managing cultural etiquette regarding the provision and consumption of food (Smith & Worsley, 2017). Qamar and Heba acknowledged that it was helpful that the

intervention addressed such considerations. Qamar noted, *"I believe it was adequate to cover my cultural needs. I enjoyed talking about the impact of feeling judged when we have visitors. I am going to try to reduce stress when I have invited someone."* Heba noted,

> *I have realised that people from my culture and religion are welcoming and show that by providing lots of food for people to eat, but I know from the workshop what is best for me. I will eat as much as I need in order to stay healthy and avoid emotional eating.*

Across a variety of cultures, social hospitality and courtesy are perceived to be an important characteristic of social interactions whereby individuals often feeling obliged to eat (Donnelly et al., 2011). Findings suggest that sociocultural considerations in accepting and rejecting an offer of food could influence participants EE, however, they felt that by increasing awareness of their food intake and reasons for eating, this encouraged them to make changes and regain control.

Finally, the use of emotion suppression and repression among participants was a shared experience perceived as negatively impacting EE. Cultural norms in respect of suppressing emotions, particularly unpleasant emotions have been widely reported among Middle Eastern populations (Lim, 2016; Tahmouresi et al., 2014; Zolezzi et al., 2018). Expressing these experiences in a supportive group environment was perceived to be beneficial in reducing social isolation and bolstering self-confidence to express and mange emotions in alternative ways. Participants felt that sharing such experiences within groups, were this to be repeated more widely, could contribute towards a reduction of stigma for middle eastern women in the UK. Neelam explained:

> *I feel that my culture makes me avoid my emotions, and other women said the same thing. It was nice to see how some other women were able to not let this affect them. I*

have been thinking more about it, which has motivated me to not react and to think if I cannot control [referring to challenges encountered and associated unpleasant emotions].

From a counselling psychology perspective, recognising culturally embedded thoughts and beliefs, such as the evil eye or perceptions of perpetual misfortune, and their influence on an individuals' emotions and behaviours is of importance (Shams et al., 2022). The therapeutic implication is that by helping individuals recognise and challenge these thoughts, therapists can empower clients to take control of their thought patterns and initiate positive changes in their emotional experiences. This aligns with the core principles of counselling psychology, which involve promoting self-awareness and fostering a sense of agency in clients' lives.

To conclude, the present intervention facilitated self-reflection, leading to a recognition of emotions and adaptive problem-solving in identifying and utilising alternative ways of regulating emotions other than through the use of food. Suzan shared:

I have realised how one person's opinion can bring me down and affect my mood for days, and I have started to question why I am affected by this so much. I usually would not defend myself, but yesterday my friend said something that was not nice, and I texted her and asked what she meant and how it made me feel. This is very unlike me, but it felt relieving.

Overall, the intervention facilitated participants' reflection on the impact of culture and religion on emotional well-being and EE. This helped to challenge negative beliefs and empower positive life changes.

7.5.2.2 Theme 2: Challenging aspects of the intervention

This theme presents aspects of the intervention that participants found to be challenging or difficult to follow. In exploring challenges, this theme will also present participants recommendations regarding how the intervention could be improved (see Figure 9).

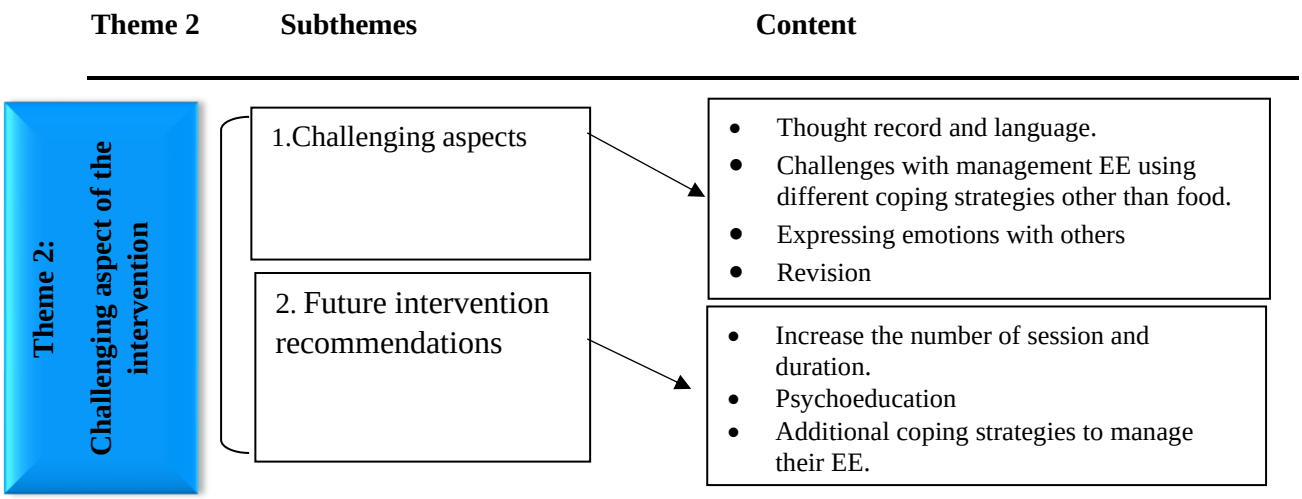

Figure 9: Theme 2: Challenging aspects of the intervention

7.5.2.2a Intervention content

When asked if participants found any aspects of the intervention to be challenging, two participants reported finding the thought record challenging to complete. The thought record involved reflecting on thoughts, emotions, and eating habits using a set of seven prompts. Rula said *"writing about my eating habits and emotions was challenging*." The challenges faced were attributed to unfamiliarity with mindfulness and reflection practices, specifically in becoming attuned to their emotions and the repercussions of their behaviours. Participants expressed concerns about how openly discussing their emotions or life events could potentially tarnish the reputation of their families or tribes (Krstanoska-Blazeska et al., 2021).

The challenges in navigating these cultural norms were apparent when participants described their intervention experiences. Qamar's said "*I feel I need to work more on coping*

mechanisms as sometimes it is challenging, and I need to keep practicing using the workbook. Suzan emphasised the complexity of opening up about emotions, stating, *"although it helped to listen to other women share their experience, I found it hard to share mine fully*", whilst Neelam shared "*culture don't let me I think"* (referring to acceptability of sharing unpleasant emotions). This signifies the significance of emotional vulnerability, with some participants expressing apprehension in expressing emotions due to fear of judgment. This aligns with research conducted by Krstanoska-Blazeska et al. (2021), which suggests that cultural beliefs play a significant role in shaping the individual's willingness to share emotions openly. The affect phobia theory (McCullough, 2003) posits that early life experiences, coupled with psychosocial factors such as cultural norms that encourage the suppression of emotions, can contribute to the development of disordered eating behaviour (Fox & Power, 2009). These findings highlight a need to destigmatise discussions around mental health and challenging emotions in interventions delivered to Middle Eastern populations. The implications for therapy include recognising the impact of early life experiences and cultural norms on eating behaviours. To facilitate this, interventions should focus on destigmatising discussions related to mental health and challenging emotions, particularly when delivered to Middle Eastern populations. This approach aims to create a more open and supportive therapeutic environment (Lim, 2016; Tahmouresi et al., 2014; Zolezzi et al., 2018).

The insights garnered from this research illustrate the complex interplay between cultural norms regarding emotional expression and effective intervention strategies. By recognising these dynamics, interventions can be designed to promote a supportive environment for sharing emotions and developing effective coping strategies.

Two participants found the intervention materials difficult to follow in English, notably CBT terminology, including terms associated with different types of Maladaptive thoughts. This challenge had been anticipated during the research planning phase, and measures were taken to address it. Specifically, the researcher sought to explain terms using simplified English during intervention sessions. Whilst the two participants recognised these efforts to simplify and explain materials, they felt it would be better to provide the materials in their native Arabic language for participants who requested or required this, in order to help navigate linguistic and cultural nuances. Shams explained, "*I struggled with remembering all the cognitive distortion and would have benefitted from translation into Arabic."* Whilst a video on the CBT cycle was provided in Arabic to facilitate understanding, a cognitive distortion worksheet had to be explained in English as an Arabic version is currently not available. This shows the importance of not only recognising potential challenges, but also acknowledging that adapting interventions to enhance cultural acceptability may involve individually tailored approaches to ensure meaningful engagement for all participants (Naeem et al., 2015; So et al., 2015). By considering cultural nuances in emotional expression and ensuring materials are accessible in languages familiar to the participants, inclusivity and effectiveness of interventions can be enhanced (Naeem et al., 2015; So et al., 2015).

7.5.2.2b Future intervention recommendations

In the context of participant feedback and recommendations, insights were sought to enhance the future delivery of this intervention program. Two challenges with the intervention were

identified, 1) the thought record (including unfamiliarity with mindfulness and reflection practices) and 2) some of the language used.

To address the challenges encountered by participants in relation to completing the thought record, a scaffolding approach (Vygotsky, 1978) is recommended for future iterations. A scaffolding approach typically includes breaking down complex concepts or tasks into smaller, manageable steps. In utilising scaffolding, begin with simpler prompts that encourage participants to make straightforward observations about their thoughts and emotions. For example: "*What was the situation or trigger that led to your current emotions?"* or *"Can you identify any specific thoughts that crossed your mind during that situation?"*. Follow this with prompts that focus on recognising and labelling emotions to help them become more aware of their emotional responses. For instance: *"How would you describe the main emotion you felt during that situation?*" or "*Were there any other emotions that accompanied the main one?*" As participants became more comfortable with the process, introduce prompts that encourage self-reflection on responses to thoughts and emotions. For example: "What did you do as a result of these thoughts and emotions?" or "Did this help or harm your well-being?". Follow up by asking participants to think about healthier coping strategies. Examples prompt could include: "What could be a more helpful way to respond to these thoughts and emotions next time?" or "What strategies or techniques have you found effective in managing similar situations in the past?" This incremental approach can help participants build confidence and familiarity with the process. Furthermore, the recommendation is to further integrate religious factors, including Quranic verses and hadiths, into interventions following the principles of Islamic Integrated CBT. This aligns with participants' positive experiences and highlights the potential for enhancing emotional expression and fostering positive outcomes.

Participants could also be provided with guided journaling templates or prompts specifically designed to help them explore their eating habits and emotions. For example:

1. Describe the specific occasion when you experienced emotional eating.
2. Identify and list the emotions you felt during this occasion.
3. Record any thoughts that crossed your mind during this occasion.
4. Describe your eating behaviour during EE episode. Include details such as what you ate, how much, and how quickly.
5. Reflect on the connections between your emotions, thoughts, and eating behaviour during this occasion.
6. Think about alternative ways you could have responded to this situation that might have been more constructive for managing your emotions.
7. Based on your reflections and alternative responses, outline a plan for how you might respond differently in similar situations in the future.

Such prompts can function as a structured framework for thought records, simplifying the process and making it more accessible for individuals (Froh et al., 2008). By breaking down the task of recording thoughts, emotions, and behaviours into specific steps, participants are guided through a systematic examination of their experiences. Moreover, this structured approach encourages individuals to be more mindful during the process. It prompts them to pay close attention to their inner thoughts, emotions, and the context of their behaviours. This heightened awareness is a fundamental aspect of mindfulness, which involves being fully present and attuned to one's thoughts and feelings without judgment. By engaging with these prompts, participants are, in essence, practicing mindfulness as they carefully observe and reflect on their mental and emotional states in the context of their eating habits. This mindfulness can lead to a deeper understanding of their behaviours and

emotions, ultimately facilitating greater self-awareness and the potential for positive change in their responses to EE triggers.

Participants also suggested that revisions be made to future iterations of the intervention to support an understanding of CBT terminology. In this regard, participants, including Nina, suggested "*maybe use more videos*" that reinforced intervention content. Indeed, research suggests that incorporating visual aids, including videos, can significantly improve the comprehension and retention of intervention material (Bishop et al., 2017; Mayer, 2014). Participants also suggested that intervention materials, including videos are provided in English and the participants' native languages, to ensure accessibility and facilitate a better understanding of concepts. Research indicates that interventions delivered in an individuals' native language demonstrate twice the effectiveness when compared to those conducted in English (Griner & Smith, 2006). Incorporating visual aids aligns with research-backed strategies for improved understanding. For example, Sabki et al. (2018) recommended the use of Islamic stories, hadith when working with Muslim clients.

Some participants noted that they would like "*more sessions and more time to discuss in more detail our experience with others*." (Neelam). These participants felt that that more sessions over a longer duration would allow time for reflective contemplation and in-depth exploration of their experiences. Studies by Smith et al. (2019) and Annise and Johnson (2020) indicate that interventions featuring prolonged engagement tend to yield more substantial positive outcomes. The extended duration provides participants with a greater opportunity to internalise new concepts, reinforce learning, and build stronger connections within the group. In this regard, two participants felt there would also be benefit in more sessions focussed on coping and means of enhancing this. Qamar remarked: *"more session on coping mechanism"* whilst Suhaila shared "*how to control negative emotions and to use*

distraction”. Such feedback suggests that more time spent exploring coping mechanisms may further support enhanced emotional regulation, a finding consistent with studies highlighting the role of coping skills in managing EE (Annesi et al., 2012; Smith et al., 2017).

In contrast to these recommendations, Noa felt: *"Sessions on this topic were very new to me, and I think they contain a lot of great information. Therefore, it was enough to start with"*. Similarly, Ahlam expressed "*the material was enough*". This variance in opinions underscores the diverse nature of participants' preferences and requirements, emphasising that a singular approach may not cater to the needs of all. This resonates with the findings of Brown et al. (2021), who illustrated the effectiveness of customisable intervention structures in meeting the varying needs of participants. Individual differences in comfort level, familiarity with the topic, and desired depth of engagement all warrant a flexible program design.

Finally, three participants felt that learning more about nutrition and physical activity could further support their management of EE management. For example, Heba noted: "*I would like to have seen more ways to improve diet to be more healthy nutrition and physical exercise*." Similarly, Suzan suggested: *"Maybe more about physical exercise and change die*t." These suggestions align with research demonstrating the value of incorporating dietary and exercise components into interventions intended to help manage EE (Hofmann et al., 2017; Katterman et al., 2014).

In conclusion, participant feedback provided valuable insights into the nuances of intervention program engagement. The convergence and divergence of opinions underscore the importance of accommodating individual preferences. By integrating participant feedback in developing and delivering future interventions, and also drawing upon relevant research, acceptability and efficacy may be further increased.

7.6 Summary

In summary, the pilot of the present intervention which sought to help individuals better manage EE produced promising outcomes, as indicated by both quantitative and qualitative data. This study contributes to the existing body of literature by illustrating the efficacy of CBT when used with non-westernized individuals in looking to better manage EE. Positive intervention outcomes included 1) increased insight into, and comfort in discussing emotions that elicited an urge to eat, 2) recognition of and experience in utilising different means of regulating emotions other than use of food, 3) increased awareness of the role of religion and culture in their relationship with food, 4) social support from the group delivery format, and 5) more favourable attitudes towards help-seeking.

Qualitative data indicate that participants found the intervention to be of benefit, substantiated by quantitative data showing a significantly reduced urge to eat in response to emotions among intervention group participants. Participants favourably perceived the integration of cultural adaptations within the CBT framework. These adaptations included modifications to language, ensuring clear explanations of complex terms, adopting a group-based approach to foster sharing of difficulties, offering intervention flexibility by considering timing and duration, and simplifying homework tasks by practicing them during sessions before assigning them for independent completion. These adjustments were derived from insights gathered in phase one and substantiated by PPIE input. Collectively, these modifications highlight the importance of tailoring interventions to specific cultural contexts, enhancing the intervention's relevance and effectiveness for the target population.

The intervention's primary focus on supporting the management of EE was achieved through multiple strategies. This encompassed heightening awareness of EE, addressing the intricate connection between physical and mental states, recognising different types of hunger, examining cultural and religious influences, promoting problem-solving skills,

cultivating acceptance, and encouraging cognitive reappraisals. This comprehensive approach facilitated the adoption of alternative emotion regulation techniques beyond food consumption (Kobylińska & Kusev, 2019). Importantly, this highlights the necessity of integrating sociocultural dimensions into psychoeducation programs. By doing so, these interventions can more effectively tackle the multifaceted challenges that individuals encounter in their efforts to regulate emotions and manage their eating behaviours.

CHAPTER EIGHT: General Discussion

8.1 Contributions to Knowledge and Counselling Psychology Practice

There has been a rise in Middle Eastern populations residing in the UK from 2.4 million in 2011 to 3 million in 2021 (Population of England and Wales, 2022). The growing cultural diversity of the UK population necessitates increased understanding of the experiences of individuals from diverse cultures in many regards, including in relation to EE. The contemporary landscape of counselling psychology emphasises cultural competence and tailored therapeutic approaches. This study provides positive contributions to this domain by offering insights into the experiences of middle eastern women with EE, in addition to cultural adaptations that can positively shape training practices and therapeutic interventions. By exploring non-Western individuals' experiences with EE and corresponding strategies for its management, the resulting insights informed the development of a four-week culturally adapted EE intervention completed by 13 Middle Eastern participants (who had identified a need to better manage EE). This intervention aimed to heighten EE awareness, identify EE triggers, and establish non-food-based emotion regulation techniques. Qualitative and qualitative data indicated that this culturally adapted intervention was successful in attaining these intended outcomes.

In developing culturally adapted interventions, the process followed in the present research is advocated. This process, along with key findings will be summarised to illustrate why this is recommended.

Step one: It is recommended that practitioners seek to understand a clients' cultural context before engaging with them. This understanding is of value due to the influences of cultural, religious, and spiritual beliefs on an individual's psyche. Initial efforts should involve exploring relevant literature and engaging in conversations with individuals from the same cultural background to establish a foundational comprehension of cultural nuances.

In the context of the present study, exploring experiential avoidance offered insight into the intricate interplay of sociocultural, psychological, and cognitive factors that shape Middle Eastern women's attitudes towards EE and help-seeking. Cultural norms deeply embedded within Middle Eastern communities significantly influence how emotions are perceived, regulated, and how EE is managed. Mental health stigma, gender roles, and religious beliefs also play pivotal roles in shaping attitudes towards EE and seeking professional support. For instance, Middle Eastern women often suppress emotions to preserve family honour and maintain group harmony, leading to the management of emotions through food consumption and acting as a barrier to seeking professional help.

The interviews gave insight into alternative mental health models, such as attributing symptoms to the "evil eye" or a perceived lack of strong faith. These culturally informed perspectives contribute to the emergence of stigma, creating further obstacles to help-seeking behaviours. Additionally, beliefs that might be considered maladaptive in Western frameworks can be intrinsic and customary within the client's cultural background. For instance, Middle Eastern women described how they engage in acts of pleasing others through culinary endeavours or prioritise familial needs over personal desires.

The imperative of familiarising oneself with the intricacies of the client's cultural fabric is emphasised as a means to mitigate assumptions, increase understanding, and strengthen the therapeutic alliance, ultimately enhancing therapeutic outcomes. Acknowledging cultural differences and recognising the reciprocity in assumptions aligns with Atkinson's (2007) proposition that professionals navigate the individual's distinctiveness while being attuned to broader contextual factors. This emphasis builds upon Duan et al.'s (2011) observations, highlighting the importance of cultural sensitivity in therapeutic practices.

Step two: The next step is to utilise the key learnings from step one to inform intervention format and content with the support of PPIE. Utilising PPIE empowers members

of the target population in contributing towards intervention development and provides researchers with valuable insights into the lived experiences of patients and the public, especially those from underrepresented communities (Teodorowski et al., 2023). In reviewing key findings resulting from a reflexive thematic analysis of interview data with a PPIE group and utilising their lived experiences as representative members of this community, several recommendations were made for intervention format and content to enhance its cultural acceptability.

During PPIE exchanges, individuals indicated an acceptance of Western therapeutic traditions with recommendations for practices that are adapted to specific cultural contexts. This finding aligns with the recommendations of researchers who argue against the universal applicability of Eurocentric therapeutic models and emphasise the need for culturally sensitive approaches (Palmer, 2000; Pilgrim, 1997). One recommendation resulting from PPIE, was to deliver the EE intervention in a group-based format. Following intervention delivery, the group intervention format received positive feedback from all participants. Middle Eastern women preferred a group intervention for various reasons. They sought connection with peers facing similar issues, including meal pattern challenges (e.g., eating with family), cultural etiquette, and managing unpleasant emotions. They believed that a group setting would enable them to openly express emotions, share ideas, and provide mutual support. Some PPIE members also thought that group sessions could help break the stigma around discussing mental health challenges within and outside the group. Sharing experiences with fellow Middle Eastern women created a sense of understanding and relief (Smith et al., 2020). Contrary to the findings of previous research (Al-Bkerat, 2019; Nehme, 2018), participants were eager to share their experiences, benefiting from the process. The group dynamic fostered openness, transcending cultural barriers and promoting emotional

expression. The study highlights the transformative power of group interventions in reshaping perceptions and fostering connections among individuals from diverse backgrounds.

Utilising culturally relevant narratives and visuals during group activities, as well as engaging clients in their native languages, ensured that the interventions resonated with their cultural experiences. In a broader context, this research emphasises the importance of holistic approaches with EE interventions. By acknowledging cultural beliefs, promoting mood acceptance, and fostering problem-solving skills, interventions can empower Middle Eastern women to effectively manage their emotions and reduce their reliance on EE. Such activities stimulated a process of self-reflection among the participants, facilitating the identification of various solutions that ultimately led to a sense of empowerment and relief. This aspect of the intervention enabled many participants to gain a deeper insight into their own thought patterns and cognitive processes. Increasing participants' recognition of any maladaptive thinking presented broader implications for emotion regulation. The realisation that cognitive distortions could influence their emotional responses brought to participants attention the value of cognitive strategies for managing emotions without resorting to food consumption. This realisation aligns with the intervention's goals, which were to equip participants with strategies to prevent of manage emotions using means other than food. In the pursuit of improved emotional well-being and cognitive clarity, participants in the study underwent a transformative journey marked by heightened self-awareness and the identification of cognitive distortions. However, it is crucial to contextualise this progress within the unique experiences of women from non-Western backgrounds, often entrusted with primary caregiving roles. Recognising the need for tailored support, this study advocates for a more inclusive and accommodating approach in therapy and group sessions. This involves practical adjustments, such as scheduling sessions during school hours and choosing convenient venues, to enhance their engagement in the therapeutic process.

Step three: This final step focusses on a review of intervention experiences and outcomes with participants, seeking ways of enhancing the intervention for future recipients with a similar background. By accounting for any recommendations in future iterations of the intervention, the specific needs and preferences of Middle Eastern women seeking to manage EE can be addressed, enhancing intervention acceptability and effectiveness.

Following review, participants made several recommendations intended to improve intervention experience and outcomes for future recipients. For example, it was suggested that revisions be made regarding the use of CBT terminology so as to increase understanding. Notably, the provision of informational videos presented in the user's native language that would help understand CBT terminology and reinforce the aims and objectives of the intervention. Ensuring clients understand what is being asked of them within the therapeutic process is paramount. This necessitates the use of strategies that support clarity and resonance. The use of simple sentence structures in CBT worksheets and providing informational videos in the Arabic language can serve as potent tools to support understanding. It is also important to acknowledge that not all individuals will explicitly indicate a lack of understanding. Non-Western clients might regard therapists as authoritative figures, and therefore may choose not to express concerns, such as a lack of understanding. The study illustrates the importance of vigilantly attending to non-verbal cues, as body language often becomes the unspoken conduit for conveying uncertainty or confusion.

Effective therapy hinges on acknowledging individuality and transcending preconceived stereotypes. Therapists are tasked with delving into the unique experiences and narratives of each client, moving beyond generalised assumptions. Central to this approach is active listening, an indispensable aspect of cross-cultural therapy (Baker, 2014). Through active engagement and genuine comprehension of the client's perspective, and by validating and

embracing cultural differences, therapists can establish strong therapeutic alliances (Asnaani, 2012, Fairburn, 2012).

This research highlights the inherent universality of human emotions and challenges, irrespective of cultural background. Insights resulting from this research advocate for a balanced therapeutic stance. Although Western therapeutic models possess intrinsic value, it is imperative for therapists to discern their relevance, ensuring interventions are harmoniously aligned with clients' unique cultural contexts. Within this context, the acknowledgment of racial dimensions in therapy stands paramount (Meyer, 2016).

In summary, this research contributes to knowledge by contributing to discourse on cross-cultural therapy within counselling psychology, specifically culturally competent and tailored therapeutic practices. As the therapeutic landscape evolves in an increasingly muti-cultural society, such insights will undoubtedly offer contributions in shaping more inclusive and impactful therapeutic interactions. By consistently embracing cultural competence and individualised approaches, clinicians can develop interventions that resonate with the multifaceted needs of diverse populations.

In scaling psychological interventions designed for Middle Eastern women, it is important for counselling psychologists to consider specific strategies that cater to their needs. One effective approach is to offer interventions in small group settings. This ensures that each participant receives adequate attention and benefits fully from the program. Feedback from participants has highlighted the need for longer interventions. Given that these women might be new to Western therapeutic methods, extending the program can help them better understand and adapt to the content.

Participants in the study expressed the value of regular contact with therapists between sessions, recognising the potential benefits of ongoing support. While acknowledging that this may not always be feasible, an additional recommendation could involve exploring

alternative means of maintaining contact and support for participants. This could include the use of technology, such as virtual check-ins, messaging platforms, or support groups, to provide a visible and accessible avenue for ongoing communication between participants and therapists. Alternatively, they could be asked to keep a log of their questions which could be discussed either one-to-one with the therapist or within the group.

Another important consideration is the translation of intervention materials into Arabic. While explanations during sessions are helpful, having materials in their native language ensures clarity and accessibility. Additionally, using visual aids like video clips can further enhance comprehension and engagement with the intervention.

8.2 Project Strengths and Limitations

The present study has several notable strengths that enhance the significance and rigour of this work and contribution to knowledge. This study is (as far as the author is aware) the first in the UK to develop and pilot a culturally adapted intervention intended to help manage EE among Middle Eastern women. The study's pioneering approach, involving target population input from start to finish, is not only innovative, but has the potential to address gaps in existing research across other contexts and populations.

As such, a key strength of this study resides in its thorough methodology, marked by the use of interviews with the target population, PPIE activities with the target population, all in order to inform the development of a culturally adapted intervention intended to help manage EE. By fostering direct engagement and open dialogue with the participants, the study harnesses their valuable insights and perspectives. This strategic inclusion of participants in shaping the intervention design not only enhances the cultural appropriateness of the intervention but also ensures its resonance and relevance within the specific context of Middle Eastern women (Wiring et al., 2018). This participatory approach aligns with the

principles of empowerment and ensures that the intervention is truly informed by the lived experiences and needs of the target population.

The study's methodological strength is also evident through the use of mixed methods to assess intervention outcomes, inclusive of seeking participant recommendations for potential improvements to further increase intervention acceptability and efficacy. In line with the objectives of a pilot study, utilising a relatively small sample size allowed for a detailed exploration of participants' experiences with the EE intervention. The focus of evaluation on acceptability, feasibility, and outcomes helped to understand what worked well and identify areas for improvement. This then informed recommendations for the refinement of the intervention for wider applications, as well as informing future research and practice considerations. Participants expressed a perception that their voices were acknowledged and integrated throughout the research. They also noted that their experiences of participant involvement would not only increase their inclination to engage in future help seeking for wellbeing concerns, but also their inclination to support others to seek help.

A further strength of this research lies in the use of homework activities in between intervention sessions. These were intended to support behavioural modifications, prevent potential relapses, and thus support the objective of supporting behaviour change beyond the supervised intervention period. By building in participant engagement in between sessions, the study facilitated ongoing reflection on, and application of acquired skills, thereby supporting confidence for behaviour change. Moreover, the integration of relapse prevention strategies acknowledges the challenges of sustained behaviour change, offering participants proactive tools to navigate potential challenges and setbacks effectively. This dual emphasis on active involvement through homework assignments and pre-emptive relapse prevention strategies illustrates the objective of this research in supporting enduring positive outcomes for participants.

Finally, the use of a group intervention delivery format was identified to be a strength, serving the dual purpose of encouraging discourse among participants regarding emotions and EE experiences whilst also discussing stigma and cultural dynamics. This was perceived as fostering a supportive environment for meaningful dialogue surrounding emotions and eating behaviours, particularly within the context of participant's culture. Through these discussions, participants were offered a safe and inclusive space for sharing thoughts and feelings that may often be suppressed due to cultural norms or stigma. Within the realm of Middle Eastern cultures, where the societal fabric can at times restrain open discussions about emotions and psychological well-being, this supportive atmosphere becomes even more pertinent.

While recognising the strengths of this research, it is equally important to acknowledge limitations that warrant consideration. One such limitation pertains to the diverse regional composition of the sample, stemming from the inclusion of participants from various Middle Eastern countries. While this approach does indeed contribute to the overall diversity and richness of the dataset (Smith et al., 2017), there may be nuances specific to individual Middle Eastern countries that could potentially be overlooked by such a heterogeneous regional sample.

A further limitation can be attributed to reliance on self-report in reviewing intervention experiences which introduces the potential for response bias. Despite asking for and looking to support honest responding, participants may have provided socially desirable or altered responses due to perceived researcher expectations. This is especially significant within the context of Middle Eastern cultures, where cultural beliefs and societal norms are intertwined with emotions and self-expression. The likelihood of sharing unpleasant emotions, particularly with individuals outside one's immediate family, can be influenced by

various factors such as mental health stigma and other cultural convictions (Dardas & Simmons, 2015; Krstanoska-Blazeska et al., 2021; Zolezzi et al., 2018).

Whilst this research makes a significant contribution toward the understanding of EE among Middle Eastern women, and the development of culturally adapted interventions, these limitations should not be overlooked. Addressing these concerns in future research will strengthen the study's impact and further promote the development of effective interventions for this population.

8.3 Recommendation for Future Research

While this study provides valuable insights into EE among Middle Eastern women, there are recommended areas for future research that should they be addressed could further increase understandings of EE among Middle Eastern populations.

- The use of purposive sampling in this study limited the exploration of EE to Middle Eastern women only. Given that previous research has indicated that men can also struggle with EE, (Guerrero-Hreins et al., 2022) future research should aim to include Middle Eastern men in the study population. This will allow for a more comprehensive understanding of EE within the Middle Eastern community and enable the development of targeted interventions for both genders.
- The inclusion criteria of English-speaking participants were necessary due to time constraints. However, this exclusion criteria prevents the representation of non-English speaking Middle Eastern women, who could have unique experiences and challenges related to EE. To address this limitation, future research should pilot the intervention with non-English speaking Middle Eastern women. This will provide valuable insights into how language barriers may impact their experiences and help tailor interventions to accommodate diverse language needs.

- Whilst the group intervention was found to be effective in managing emotions, some participants in this study felt that the intervention duration was too short. Future research could explore the effectiveness of more extended group intervention sessions to allow for a deeper exploration of emotional challenges and foster stronger peer support and learning within the group setting.
- Given that the study was conducted within a specific cultural context, it may be beneficial for future research to investigate EE among Middle Eastern women living in different countries or cultural settings. This would enhance the generalisability of the findings and provide a more comprehensive understanding of the cultural factors influencing EE in diverse Middle Eastern populations.
- Although the study focused on EE, future research could explore the broader context of eating behaviours and patterns among Middle Eastern women. Investigating factors such as body image, dietary habits, and cultural norms related to food could offer a more holistic understanding of the complexities surrounding eating behaviours in this population.
- Intervention strategies that integrate religious principles should be examined in future research. This proposition stems from the discerned influence of religion on individuals' management of emotions and their inclination towards seeking support which has been supported by other researchers (Asamari, 2018; Cucchi, 2022).

In conclusion, whilst this study has generated new knowledge, and contributes to the understanding of EE among Middle Eastern women, future research should strive to address these recommendations to further advance understandings of EE and support enhanced mental well-being among Middle Eastern communities.

8.4 Reflexive Summary

Reflexivity demands an acknowledgment of the researcher's input in the development of meaning throughout the research process, along with an understanding of the futility of remaining outside one's frame of reference while conducting the research project. Therefore, I have strived to remain open-minded and aware of my own beliefs and how they may have influenced the analysis, both as a Middle Eastern individual and researcher. However, I also acknowledge that it is inevitable that my perspectives have influenced the research process. Situating this project within the constructivism paradigm, I recognise the existence of multiple realities and the role of language and culture in shaping and constructing these realities.

To account for this, I have engaged in various reflections throughout this journey, particularly as my doctoral research neared its culmination (see Appendix H & P for a summary of personal reflections). My experience has been meaningful and exciting, yet challenging at times, as I could not always see the end in sight. My passion for supporting others, particularly as an advocate for middle eastern women and the potential positive changes this can bring, has helped me navigate through these difficulties.

The most rewarding aspect of my research was listening to the participants and gaining insight into their needs, which informed the development of a culturally adapted intervention. This is of utmost importance to me as a researcher and, above all, as a therapist, as psychological interventions yield better outcomes when tailored to the specific needs of the client/patient. Engaging with Middle Eastern women has expanded my knowledge and awareness in various areas through their narratives, encompassing their struggles and difficulties. Although I was born in a Middle Eastern country, my experiences in certain aspects have been different, such as having the opportunity to pursue education while being a wife and mother. This evoked mixed emotions within me; on the one hand, I felt grateful for

such opportunities, while on the other hand, I experienced anger and occasional guilt knowing that some participants lacked similar opportunities. I notice similar feeling when interviewing the participated in which they shared their unmet needs.

These reflections emerged from the process of data analysis, which I thoroughly enjoyed. The qualitative phase served as a significant learning experience, which I have found to be particularly beneficial for my clinical work when interacting with individuals from diverse backgrounds. For example, the use of bracketing in qualitative research has enhanced my ability to bracket my own experiences when working with clients whom I can relate to, thereby enabling me to focus on their unique perspective.

Adopting the mixed methods approach has provided me with several beneficial outcomes, including research skills such as utilising SPSS and interpreting data. It has prompted me to reflect on how my epistemological views align with the use of quantitative methods, leading me to depart from a "one size fits all" approach and appreciate the synergy that both qualitative and quantitative approaches can offer. Moreover, having numerical data to evaluate the intervention has proved advantageous in multiple ways. It allows participants to consider tangible evidence of the intervention's impact, thereby enhancing their motivation to persist with an intervention, or engage in future interventions. From a researcher's standpoint, it provides evidence of the positive outcomes resulting from an adapted intervention that caters to cultural needs. I must admit feeling anxious about the intervention's effectiveness, particularly regarding whether CBT techniques and methods would resonate with this population in addressing emotional eating. I also harboured concerns about participants' engagement with homework tasks and whether they would perceive EE as something they were sufficiently motivated and felt suitably empowered to address.

Upon reflection, I believe that psychoeducation on the mind-body connection, introducing different types of maladaptive thoughts, distinguishing between physical and

emotional hunger, and fostering problem-solving skills were positively received and deemed beneficial to support them with managing their EE. Prominent clinicians, including Sheik (2018) and Thomas (2013), emphasise the need for alignment between Cognitive Behavioural Therapy (CBT) and Islamic principles. They argue that CBT's core elements, especially its focus on the interconnectedness of thoughts, emotions, and behaviour, as described by Greenberger and Padesky (1995), resonate with Ghazali's (1986) conceptualisation of the human psyche. This model encompasses the nafs (self), qalb (heart), Ruh (spirit), and aql (intellect). However, CBT's historical development has often overlooked religious dimensions, with its roots predominantly embedded in American cultural paradigms, emphasising cognition and rationality (Imawasa & Hays, 2018). Researchers have advocated for the integration of religious perspectives within CBT (Badri, 2013, Cucchi, 2020; Ghazali, 1986). Pearce et al.'s (2015) ABCD-R-E Model, for instance, extends traditional CBT by incorporating religious considerations, encompassing psychoeducation, behavioural activation, and discussions on spiritual facets such as gratitude. Cucchi (2022) further recommends infusing CBT's cognitive restructuring with Quranic scriptures, an approach found beneficial in clinical settings. Additionally, leveraging the teachings of Prophet Mohammed, Socratic questioning with a spiritual focus and behavioural activation methods can be adapted, aligning therapeutic strategies with Islamic teachings. Furthermore,

Examining Ghazali's (1986) conceptualisation of the "nafs" suggests its potential association with the behavioural component of the Hot Cross Bun in CBT. Specifically, it aligns with safety behaviours and behavioural inclinations aimed at soothing immediate urges. This means that when faced with the dissonance between the "aql" and/or "qalb," an individual may surrender to behavioural impulses to silence certain components of the psyche. Indulging the "nafs" might provide momentary relief, albeit short-lived, potentially triggering a cycle where anxiety arises if the "nafs" is not consistently satisfied (Cucchi,

2020). Consequently, this means that the lack of harmonious equilibrium between the various elements constituting human nature is perpetuated, as outlined in Greenberg and Padesky's (1995) model of CBT.

The problem-solving process and the act of writing down their problems and identifying various options were particularly enlightening for the participants. During these sessions, everyone would support each other by sharing their experiences and suggesting helpful strategies they had utilised in the past. This highlighted the benefits of group therapy, where participants realised that their current challenges were once faced by others, and they learned from listening to the coping strategies used. This can foster hope and illuminate a path forward as well as normalise sharing struggles with EE.

Undoubtedly, working with a group of women who shared similar problems related to emotional eating, albeit influenced by diverse factors, provided ample opportunities for sharing. This was especially evident in sessions 3 (Problem-solving, managing unhelpful thinking and mood regulation**)** and 4 (relapse prevention and continuity)*,* where participants grew more comfortable sharing their experiences. Consequently, some participants would digress from the topic, making it challenging to steer the discussion back to the intervention's intended focus. This may also explain why it took longer than the allotted 10 minutes to reconvene after short breaks, as participants would form smaller groups of two or three to further reflect or continue sharing their thoughts. However, I remained mindful that participating in psychological interventions and group settings is a new experience for many participants, and such deviations were to be expected. It may therefore be useful to conduct session in smaller groups or allocate 10-20 minutes time at the end of the therapy session for the participants to talk to each other.

The process of writing my thesis in English proved to be the most formidable challenge in my research journey, evoking frustration and disappointment. Striving for perfection and aiming to write without anxiety, especially during the second phase of the study, set high expectations that often triggered unhelpful thoughts and procrastination. My sense of self played a crucial role during this phase as I grappled with self-imposed pressures.

Fortunately, the unwavering support of my supervisor became instrumental in helping me navigate these challenges. With perseverance, I managed to overcome obstacles and successfully complete the write-up of my thesis. Reflecting on this experience, it became evident that my sense of self, particularly my confidence and resilience, played a pivotal role in the face of adversity. With regards my sense of self, undertaking the doctoral thesis not only enabled academic growth, but it has also fostered significant personal and professional growth. Initially grappling with low confidence, I found that each year of training gradually transformed me, empowering me to make clinical decisions and assert myself as a counselling psychologist in training. Juggling the roles of a mother, wife, and researcher presented its own set of challenges, but the unwavering support from my family helped me to manage these roles more efficiently. As a Middle Eastern woman, I keenly sensed the pressure of having to compartmentalise my insecurities and intense emotions related to my thesis because of the cultural expectations of others. I distinctly recall one school mother (Kurdish) expressing concerns, asking whether I felt sorry for my son being in nursery at such a young age while I pursued my academic aspirations. While this comment was undeniably challenging and hurtful, I endeavoured to empathise with her perspective and cultural expectations.

Navigating external pressures such as this required resilience, and with the steadfast support of my family, I managed to overcome such moments of self-doubt and refocus on my

academic goals. Acknowledging the cultural nuances surrounding perceptions of motherhood and career pursuits, I learned to balance cultural expectations with my personal and professional aspirations. This experience not only strengthened my determination but also reinforced the significance of having a supportive network to navigate the complexities of academia while maintaining a sense of self. This journey has also taught me the importance of embracing the concept of being "good enough" in various facets of life.

Completing this programme of research has deepened my commitment to reflexivity in my professional practice and fuelled my passion for aiding minority groups facing challenges, specifically mental health, inclusive of EE. Conducting mental health awareness sessions for women and young people from Middle Eastern cultures was a rewarding experience that enhanced my skills in setting and maintaining boundaries. This newfound confidence extended beyond research, influencing my clinical work, where I now feel comfortable voicing opinions and advocating for patients within multidisciplinary teams.

The skills acquired through this project have motivated me to critically evaluate our work as counselling practitioners, particularly within the eating disorder service. Furthermore, it has inspired me to continue to engage in research, a commitment I eagerly share with fellow practitioners at work. Despite the inherent challenges, I recognise the inherent value of research and the meaningful data it generates, reinforcing my dedication in contributing to the field.

Reflecting on my choice of methodology, while it demanded substantial effort and presented challenges, I gained valuable insights from conducting both qualitative and quantitative research. While I acknowledge that the qualitative approach may not be fully generalisable, it held great value for this project, particularly when working with minority

groups with limited published information. Inclusion of participants from different Arabic countries who shared similar experiences enriched the research process.

The use of PPIE also proved to be highly beneficial. PPIE facilitated openness and engagement among PPIE members during their involvement, increasing the likelihood of tailoring the intervention to the specific needs of Middle Eastern Women and achieving positive outcomes, a fundamental goal in psychology. Furthermore, the skills I acquired through PPIE have allowed me to explore patients' experiences and beliefs regarding psychological group interventions within the eating disorder unit where I work as a trainee psychologist. The resulting insights have led to amendments in intervention content, which patients have positively perceived, such as the addition of compassion-focused interventions to the program.

The collection of quantitative data might appear to be at odds with my constructivist stance, however, this quantitative feedback mechanism provided participants with an opportunity to reflect on their intervention experience. The subsequent reflections provided a more nuanced understanding of the intervention's influence on the management of EE. In the context of my constructivist orientation, this qualitative feedback is particularly relevant, as it emphasises the centrality of individual experiences in shaping knowledge and understanding.

Finally, I consider myself incredibly fortunate and privileged to have had the opportunity to hear the stories of the participants, and I am immensely proud of these women for bravely navigating their anxiety and cultural attitudes to disclose unpleasant events and emotions. I am aware that this requires tremendous courage, particularly within a group setting. This experience has encouraged me to share my vulnerabilities within supervision, and I take pride in knowing that I have contributed knowledge and support to these women.

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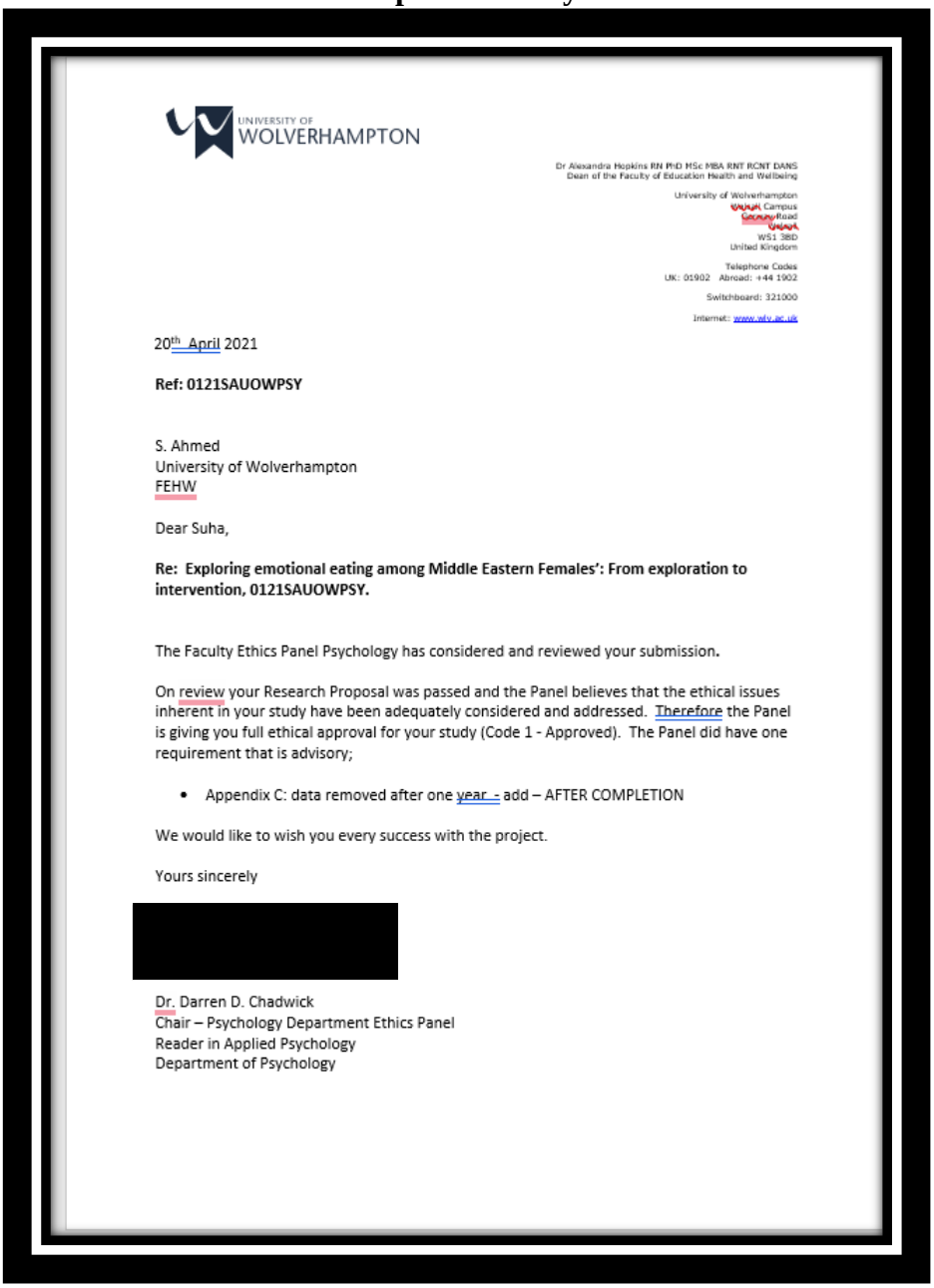
Appendices

List of appendices for phase 1

Appendix A: Ethical approval from The University of Wolverhampton for Phase one of the present study.



UNIVERSITY OF WOLVERHAMPTON

Dr Alexandra Hopkins RN PhD MSc MBA RNT RCNT DANS
Dean of the Faculty of Education Health and Wellbeing

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20th April 2021

Ref: 0121SAUOWPSY

S. Ahmed
University of Wolverhampton
FEHW

Dear Suha,

Re: Exploring emotional eating among Middle Eastern Females': From exploration to intervention, 0121SAUOWPSY.

The Faculty Ethics Panel Psychology has considered and reviewed your submission.

On review your Research Proposal was passed and the Panel believes that the ethical issues inherent in your study have been adequately considered and addressed. Therefore the Panel is giving you full ethical approval for your study (Code 1 - Approved). The Panel did have one requirement that is advisory;

- Appendix C: data removed after one year - add – AFTER COMPLETION

We would like to wish you every success with the project.

Yours sincerely

[redacted]

Dr. Darren D. Chadwick
Chair – Psychology Department Ethics Panel
Reader in Applied Psychology
Department of Psychology

Appendix B: Participants information sheet

Title of the study:
Exploring EE among Middle Eastern Females': From exploration to intervention.

Who is conducting the study?
The research will be conducted by Suha Ahmed a Counselling psychologist in training at The University of Wolverhampton.

What is the study about?
This study aims to explore the relationship that women of Middle Eastern culture have with food. Specifically, how your emotions influence eating habits and what effects, if any, such as your culture has on this. As an extension of this, we will explore any techniques you may have used to help manage' emotional eating' as well as how effective these were. It is important to note that you don't need to have had any previous treatment or intervention.

Why am I being invited to take participated?
The current research is looking to recruit Middle Eastern women who have identified that emotions influence their eating habits and wish to better manage this. It is not appropriate to take part in this research if you identify with having an eating disorder or are diagnosed with an eating disorder as this requires a very different approach to treatment and intervention.
If you self-identify with the ethnic heritage of the following Middle Eastern countries: Egypt, the Arab countries of Asia (Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, United Arab Emirates, Yemen), Israel, Turkey, and Iran then you are invited to participate in this study.

What will taking part involve?
There are two phases to this study. Firstly, this research requires a 40–50-minute interview whereby you will be asked to talk about your experiences of emotions influencing you're eating behaviours.
The second phase of the study involves taking part in an intervention to help manage emotional eating. The specific details regarding the intervention will be informed by information gathered from phase one.

Do you have to take part?
No, your participation is voluntary.
If I take part in the first phase does this mean that I need to take part in the second phase?
No. your participating in both phases is completely voluntary and there is no obligation, participants are free to withdraw from the study at any point. However, your participation will be greatly appreciated, and consent will be sought before starting phase two of this study.

Where will the interview take place?
The interview will be conducted via a safe online platform such as Zoom or Teams. If you are not familiar with Zoom or Teams, the information will be provided on the use of these apps. The interview can be either with video or with audio-only.

What if I want to drop out?
If you wish to drop out at any stage during the interview, then please just let me know. If you wish to withdraw your data gathered from the interview, you can do this, without any impending consequences up to two weeks following taking part in the interview. This can be done by contacting the researcher on the detailed provided below.

Will the information I give you to be kept confidential?
The information obtained in the interview will be treated with the strictest confidence throughout the study and your data will be stored on the University password protect file. The audio recording will be deleted on completion of transcription and the transcriptions will be kept in a securely locked cabinet. Further, any identifiable information will be kept confidential when storing the data and in the written research such as your name or location. This will be done by using a pseudo name which you will be asked to choose when agreeing to take part in the study.

What if I do not want you to include certain things I have said in my interview?
If during the interview you say something which you decide you do not want me to include in my study, then please just say during the interview that you would like that omitted from the analysis and the completed report. Alternatively, you have up to two weeks after the interview to inform me about any information you would like taken out.

What if I do not want to answer any questions?
If you do not wish to answer any of the questions that I ask you during the interview / that are included in the study, please just say so and I will move on to the next question.

What if I am upset by anything during the study?
If this happens, you might like to take a break, or if you prefer, you can decide to end your participation and withdraw from the study at that point. If you decide to withdraw, I will provide you with a copy of the debriefing sheet. [The debriefing sheet contains information about sources of support you can access if there is anything you wish to talk about in confidence].

Who will have access to the recording / raw data?
Only the researcher and the researcher's supervisor will have access to the recording and raw data.

Who will have access to the transcript of my interview?
The researcher, the researcher's supervisor, second markers from the Psychology department, and an external examiner will have access to the fully transcribed interview. Please be aware that your personal information will have been removed such as your name before allowing supervisors to have access to your data.

Who will see the finished report?
Extracts from your interview data may be included in the finished report. This will may mean that the transcript and final report will be seen by the researcher's supervisor and a second marker from the Psychology department and possibly by an external examiner.

What will happen to my interview recording and transcript?
All data will be kept in secure storage (to which only the researcher has access) for ONE year and will be destroyed after that, according to departmental policy.

Who has approved this study?
Approval for this study has been granted by The University of Wolverhampton, Division of Psychology, Sport and Exercise, Ethics Committee.
If you wish to raise concerns regarding research being undertaken by the University, you may wish to contact the research integrity leads in the first instance.
The senior lead for research integrity is the Dean of Research - Professor Silke Machold.
The administrative lead is the Research Integrity Manager - Miss Jill Morgan.

Is there anyone I can talk to about the study before I take part?
You are welcome to contact me if you have any question about the study. Alternatively, if you wish to talk to someone else about the study before taking part, then please feel free to contact my project supervisor using the contact details provided at the end of the information sheet.

I know a friend who may be interested; can she participate in your study?
Yes, certainly if your friend meets the criteria mentioned above. Your friend can contact me directly to discuss the study.

Are there any specific services I can contact to get help?
Yes, please find the details below:

- **BEAT (Eating Disorder service)**
- **Helpline: 0808 801 0677**
- **Student line: 0808 801 0811**
- **Youth line: 0808 801 0711**

- IAPT Birmingham (Participants will be informed about other IAPT services within their city) 0121 3012525.
- SAMARITANS: Tel: 116 123 or Email: [e-mail address redacted]

Thank you for your time and if you decide you would like to participate in my study, please contact me. My contact details are as follows:

Researchers contact details:
Suha Ahmed Email: [e-mail address redacted]
Supervisors contact details:
Prof Tracey Devonport Email: [e-mail address redacted]
Dr Jennifer Lim Email: [e-mail address redacted]
Dr Gurpinder Lalli Email: [e-mail address redacted]

Appendix C: Consent sheet.

Researcher name:
Suha Ahmed
Researcher Contact details:
[e-mail address redacted]
Participant number or pseudo name

Please read the following items carefully and write your initials or a tick in the box to indicate that you have read, understood, and agreed with each item.

I am over 18 years of age and voluntarily agree to take part in this study.	☐
I have read the information sheet and understand that this study is conducted Part of the doctoral thesis project.	☐
I understand that I will take part in an interview lasting approximate between 50-60 Whereby I am asked to respond to a series of questions.	☐
The purpose and nature of the study has been clearly explained to me and I was Given the opportunity to ask any question about the study.	☐
I understand that the interview will be audiotaped, if required I may request for the recording to be paused or stopped at any time without any penalty by Informing the researcher accordingly.	☐
I understand that I will not benefit directly from participation in this study.	☐
I have been allowed to ask any question regarding the study and supervisors contact details have been provided to me.	☐
I understand that my data will be fully protected following the Data Protection Act of 1998, and in compliance with the British Psychological Society ethical guidelines, and that my data will be kept confidential and anonymous until they are securely destroyed.	☐
I understand that my name and any personal details will be anonymised this will be done using numbers or pseudo names.	☐
I agree that any of the data I provide will be used for the thesis project and possibly used for publication in academic journals.	☐
I understand that in case the data are used for publication, they will be kept until five years after the article has been published, and then destroyed.	☐
I understand that if I so wish I may have a copy of the recorded interview and or/transcript.	☐
I understand that disguised extracts from my interview may be quoted in the writing up of the thesis or journal article for publication.	☐
I understand that if I inform the research if I am or someone else is at risk of harm, they may have to report this to relevant authorities.	☐
This with me but may require doing this without my permission.	☐
I am aware that a transcript of my interview in which all identifying information has been removed will be retained for two years. (until the thesis has been completed).	☐

Signature of researcher: **Signature of participant**

Date: **Date:**

Thank you again

Appendix D: Participants Debrief form.

I would like to thank you again for your participation in the first phase of the present study Exploring Middle Eastern females' relationship with food. The data obtained will be used as part of a thesis project as well to develop a culturally adapted intervention, leading to the second phase of the study. The developed intervention will be carried out over 6-8 weeks. If you are interested in taking part in the intervention, please contact me as soon as possible using my email address provided below. Alternatively, if you have any female family or friend who is interested in taking part in the interventions, please provided them with my contact details.

If you have experienced any psychological difficulties from taking part in this study, please contact me or any of the supervisors who are listed below. If you feel uncomfortable contacting us, then please contact your GP or any available counselling service. Please be reminded that your data will be kept confidential and completely anonymous. The audio recordings will be kept in a password-protected file and the data will be destroyed after 1 year of thesis completion. In case of the data being used for academic publication, transcripts will be kept for five years from the date of publication.

Please make a note of your participant number/pseudonym. If you wish to withdraw your data you need to contact the researcher using the contact details below and quote your participant number/pseudonym, before 01/10/2021. No other information is required, and you will not be asked to provide a reason.

If you require additional information, please do not hesitate to contact me or my supervisors.

Thank you again for your participation.

Researchers contact details:

Suha Ahmed Email: [e-mail address redacted]

Supervisors contact details:

Prof Tracey Devonport Email: [e-mail address redacted]
Dr Jennifer Lim Email: [e-mail address redacted]
Dr Gurpinder Lalli Email: [e-mail address redacted]

Appendix E: Semi-structured interview questions phase 1

General biographic questions:

- Could you start with telling me a bit about yourself?
- *Where were you born?*
- *Are you married?*
- *Do you have children?*
- *How old are you?*
- Could you tell me your country of residence and how long have you been living there?
- Could you tell me more about your everyday life: do you study, work, or be a housewife?

Exploring EE awareness and experiences:

- Can you tell me a little bit about your daily eating habits? E.g. how many meals do you typically have a day?
  Do you snack in between at all?
- Could you tell me what EE means to you?
- How do you know when you are eating emotionally? What does it feel like to you?
- Are there particular triggers or situations that trigger emotional eating?
- Are there particular emotions being more likely to lead to you emotional eating? For example, are you more likely to eat when you feel, bored, happy, calm, angry, sad, or stressed? If so, please tell me more about this.
- What type of foods do you eat when feeling the emotion(s) you have identified?
- Do you find it challenging to stop eating certain foods when feeling the emotion(s) you have identified?
  If so, why do you think this is?
- How do you feel after emotional eating? Does result in a particular emotional feeling for you afterwards?
  If so, what, and why do you think this is?
- Have you noticed any triggers or occasions where you eat more?
- Can you think, and describe in as much detail as you are able, the last time you recall emotionally eating?
- Do you feel more or less in control when eating certain food types?

Exploring EE and Cultural experiences:

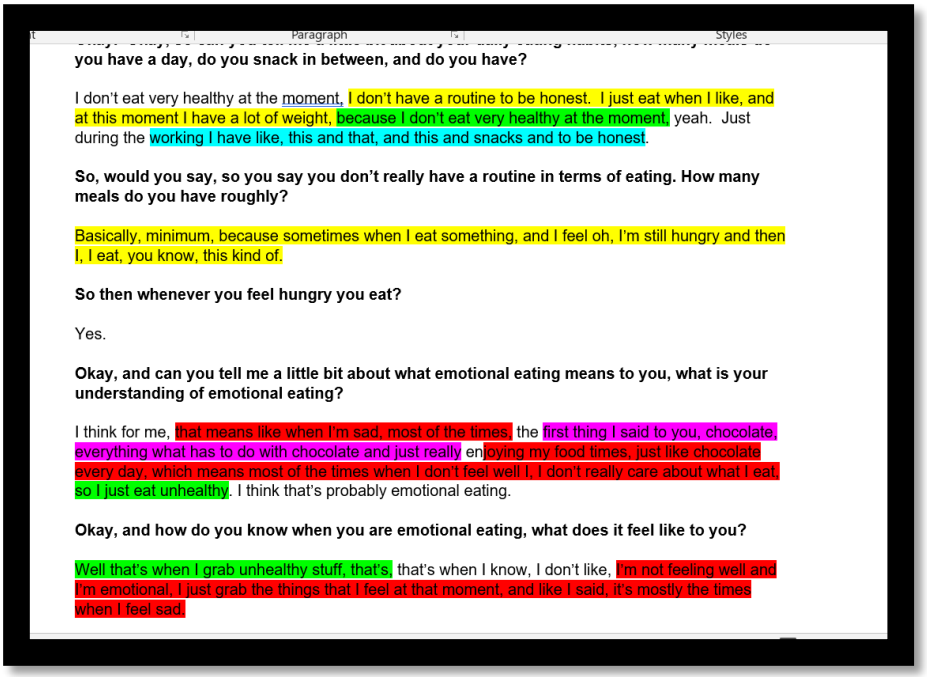
- How is food used in your culture relative to emotional experiences?
- How is EE viewed?
- Do you feel this has changed since living in the UK? If so, how?
- Is there anything else to add about the causes of emotional eating, your experiences of emotional eating,
  or consequences that we have not discussed that you would like to add?
- Is there any cultural beliefs which may impact on management of emotional eating?

Exploring participants knowledge and experience managing and general knowledge of EE interventions as well as their needs:

- Have you ever taken part in any emotional regulation intervention?
  If not, can you tell me why this might be?
- Have you personally done anything that has helped with emotional eating?
- Have you tried anything that you think was supposed to help but did not?
- What do you think an EE intervention should include?

- Is there anything that you think would be helpful? But you have not had the opportunity to try? Or have not been offered?
- How do you judge how helpful an intervention to help reduce EE has been?

Appendix F: Example of Participant interviews



Paragraph Styles

you have a day, do you snack in between, and do you have?

I don't eat very healthy at the moment, I don't have a routine to be honest. I just eat when I like, and at this moment I have a lot of weight, because I don't eat very healthy at the moment, yeah. Just during the working I have like, this and that, and this and snacks and to be honest.

So, would you say, so you say you don't really have a routine in terms of eating. How many meals do you have roughly?

Basically, minimum, because sometimes when I eat something, and I feel oh, I'm still hungry and then I, I eat, you know, this kind of.

So then whenever you feel hungry you eat?

Yes.

Okay, and can you tell me a little bit about what emotional eating means to you, what is your understanding of emotional eating?

I think for me, that means like when I'm sad, most of the times, the first thing I said to you, chocolate, everything what has to do with chocolate and just really enjoying my food times, just like chocolate every day, which means most of the times when I don't feel well I, I don't really care about what I eat, so I just eat unhealthy. I think that's probably emotional eating.

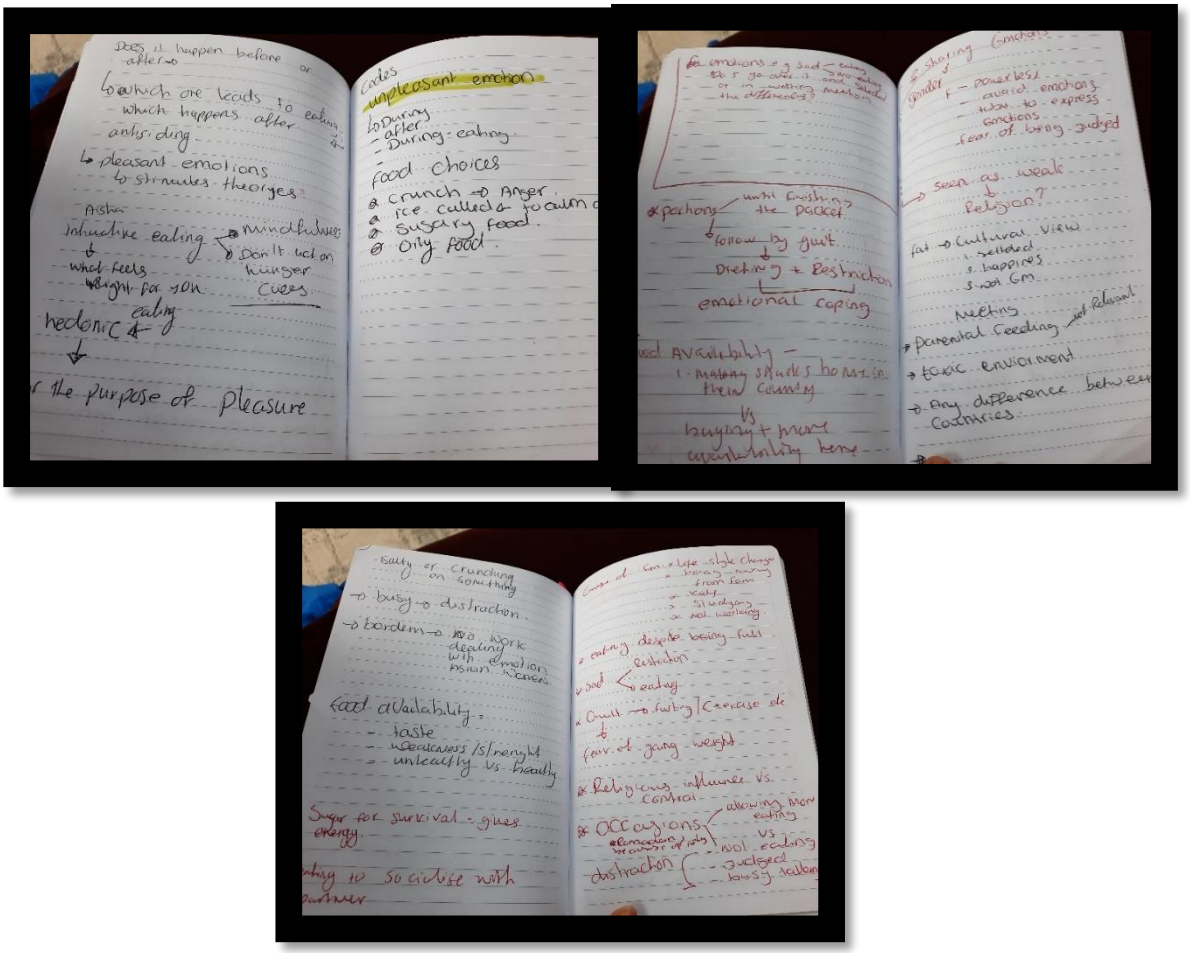
Okay, and how do you know when you are emotional eating, what does it feel like to you?

Well that's when I grab unhealthy stuff, that's, that's when I know, I don't like, I'm not feeling well and I'm emotional, I just grab the things that I feel at that moment, and like I said, it's mostly the times when I feel sad.

Appendix G: Step-by-Step data analysis: Following Braun and Clark's (2019) guide for thematic analysis.

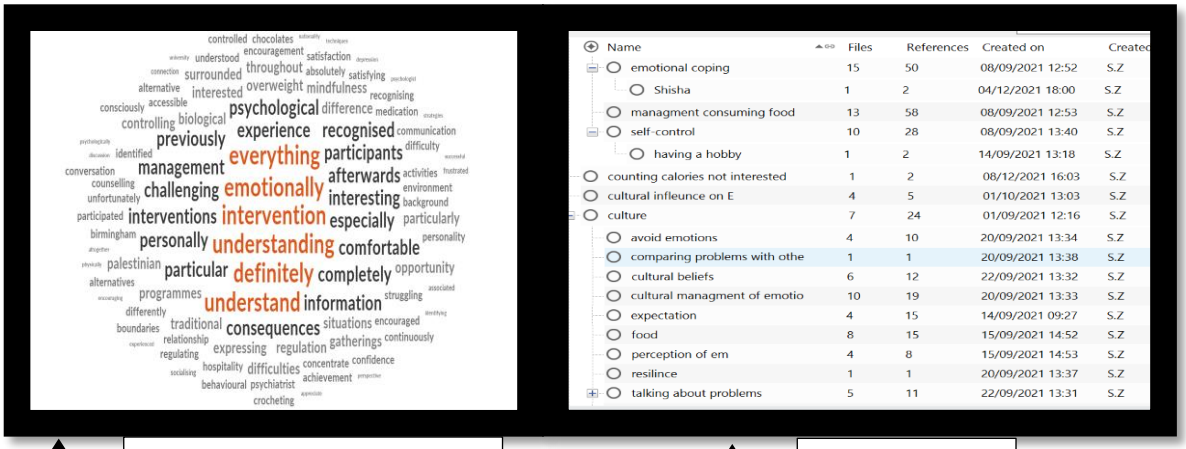
Step one

The first step of analysis involved data familiarisation through transcribing the interviews, read and re-reading, then making initial notes. Below is a screenshot of the initial thoughts and observation following reading interviews line by line.



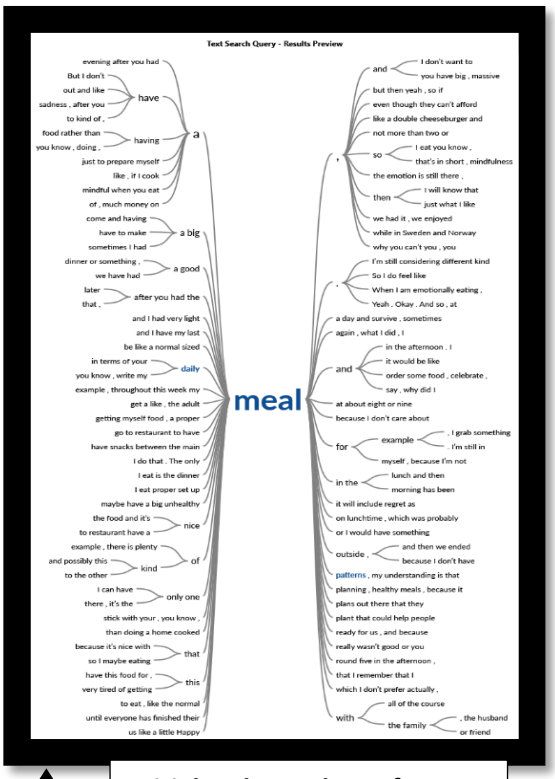
Step 2:

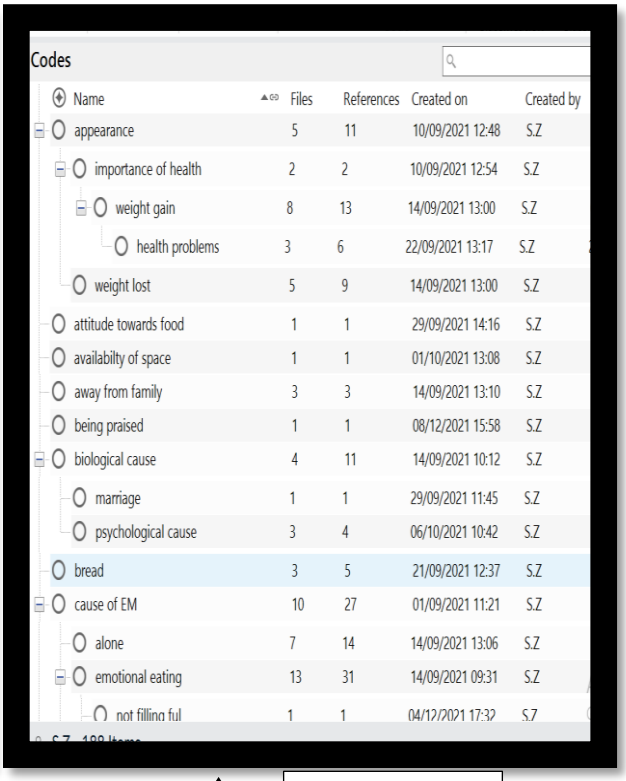
Second, initial codes were developed coding line by line to retrieve and organise the data into meaningful groups using NVIVO. Following this process, it was possible to draw comparisons across the transcripts. Below is a screenshot of initial codes e.g., cultural influences on EE, perception of EE, emotional coping, self-control.



Overview of common word

Initial codes



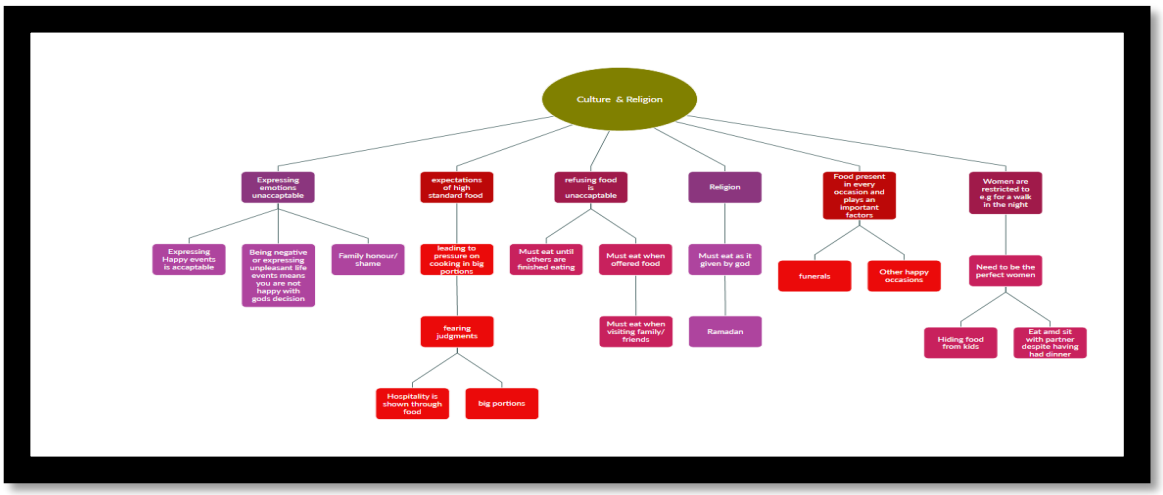


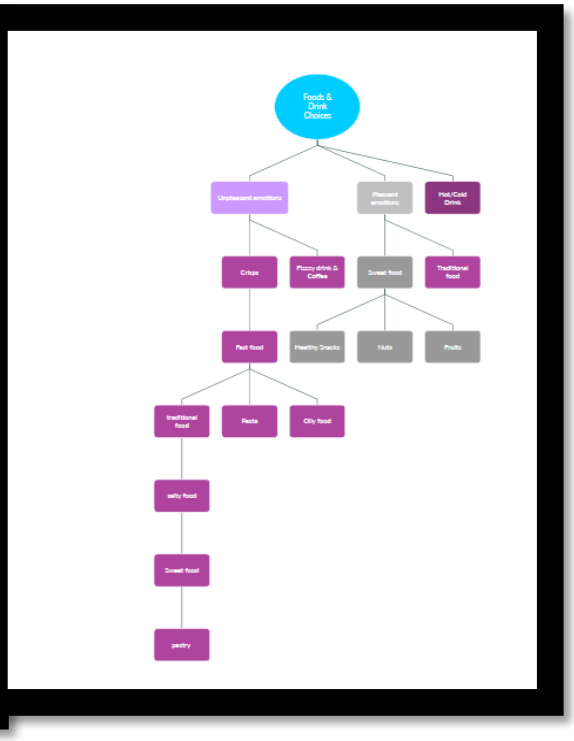
Initial codes and text from the interviews related to the code 'meal.'

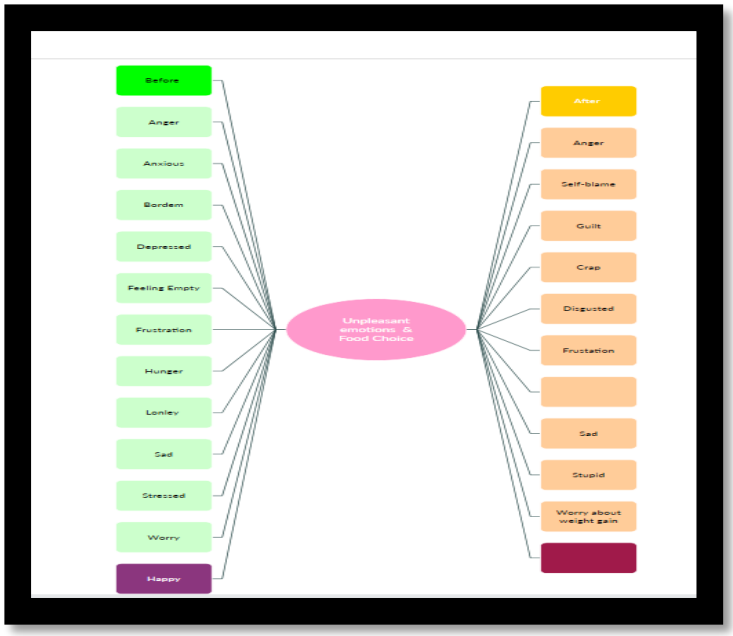
Initial codes

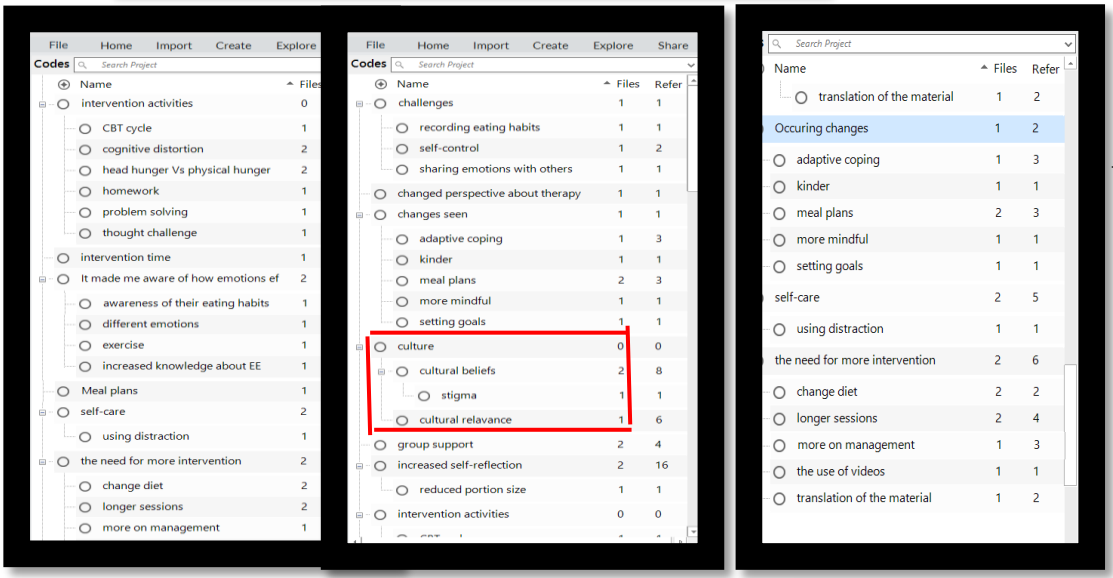
Step 3:

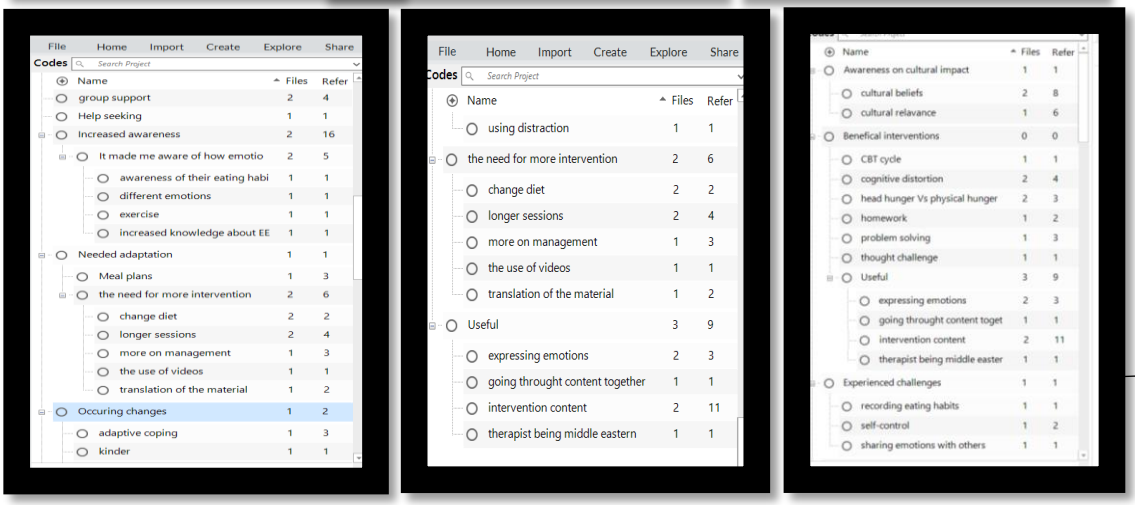
Third, the codes were grouped into possible higher order themes, whereby time was spent finding meaning in order to develop theme titles. Below is a screenshot of codes which were grouped together and related sub-codes which reflected the main code.







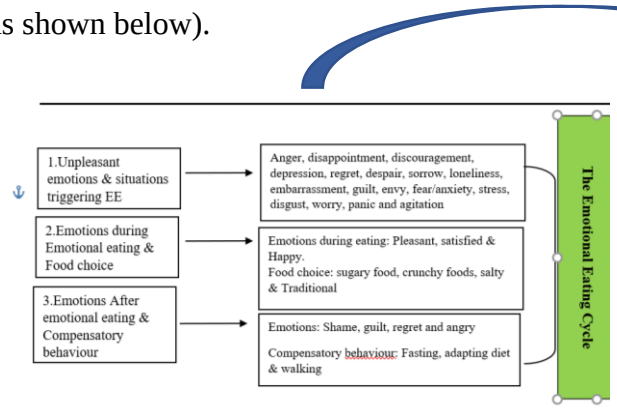


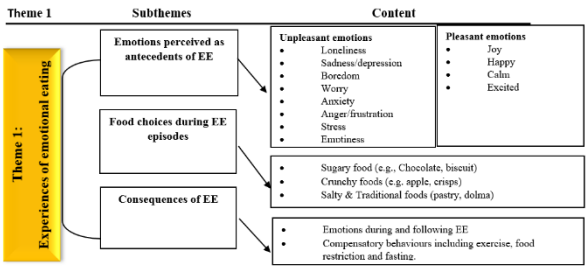


Codes grouped into theme and associated sub-themes in NVIVO.

Step four:

In the fourth stage, themes underwent a comprehensive review and underwent necessary alterations. For instance, the theme 'the emotional eating cycle' was transformed into 'experience of emotional eating,' and the subheadings within it remained consistent in context (as shown below).





Step five:

Stage five involved defining and naming themes to align with the research questions. During this phase, transcript extracts were selected to create an analytical report. This necessitated contextualising participant extracts within existing literature when reporting the results, which is considered acceptable in Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2013). See findings in phase one of the study.

Step 6: Additionally, theme names were carefully reviewed to ensure they were informative, concise, and memorable (Braun & Clarke, 2020). In the final phase, the thesis was prepared, adhering to the guideline that themes should ideally build upon previously identified themes, while also being able to convey individual stories independently from the rest of the themes as suggested by Braun and Clarke (2020).

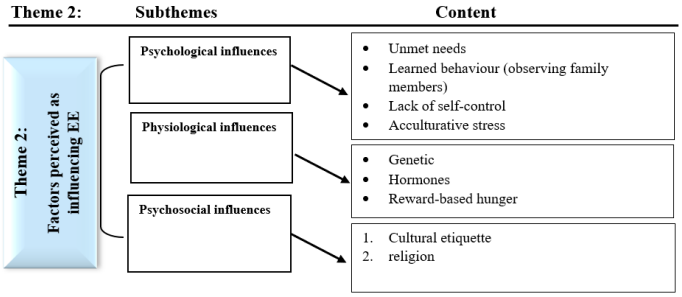
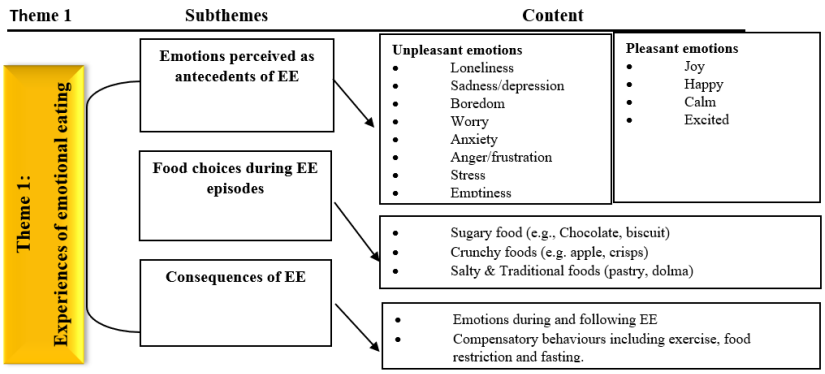


Figure 5: Factors perceived as influencing emotional eating.



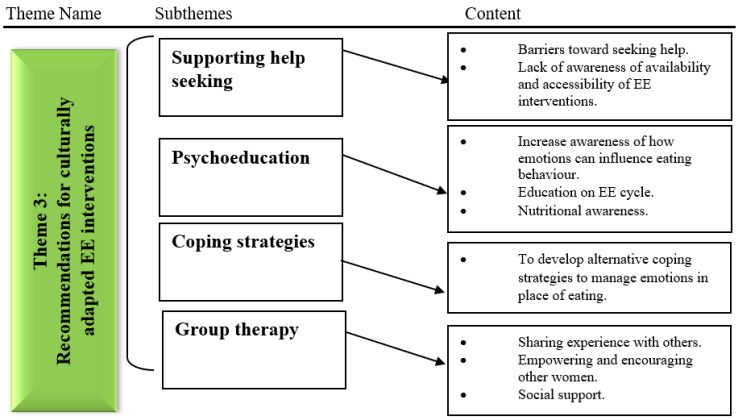


Figure 6: Recommendations for culturally adapted EE interventions

Appendix H: My time in Iraq summer 2022 observation

Observing and asking other people about their beliefs regarding food and emotions over period of 6 weeks.

Responses summary:

1. **Food.** There is great importance placed on food and pressures to cook a good dish. For example, foods such as sawar (bulgur) are considered shameful to cook as they are classed as food for poor people.

2. When exploring what shame means in terms of cooking, the following answers were given:

- People will judge us by the food we cook. Cooking small or one type of dish is seen as not being a good host.
- People will talk about us in the gathering, and we will be labelled as bad hosts, shameful families, and greedy.
- Not cooking and providing meat with any food means you are not welcome as a visitor.
- When inviting people, asking what they would like the host to cook for them is shameful as it is classed as the host not wanting you to come.

3. Drinks such as fizzy drinks are considered good services and show that the family is well off or middle class.

4. I observed a pattern in terms of which order and what type of food is served which has also messages behind it:

- Water is served on arrival, indicating welcome and to refresh yourself (perhaps because the weather is hot most of the time). The host will stand in front of you until you finish the water, which often pressurises you into drinking this in one go.
- Tea and biscuits are served without requesting it. The majority of people automatically add sugar to the tea. You need to ask for without sugar but often those who feel uncomfortable asking for tea without sugar drink it anyway. This is because it is shameful as you are making the host do more work for you. You will be asked if you want second tea; refusing this can be hard at times, because you will be given another one. This is because they want to prevent you from feeling shy to ask for another one.
- Nuts are offered (sometimes with coffee or juice, depending on the weather). This indicates that they have almost offered everything they have in the house.
- Fruits are offered which indicates that it is time to leave.

5. Breakfast is eaten between 7-9 am, lunch begins around 12-1 pm (the main meal which involves a lot of preparation), and dinner is eaten around 7-9 pm, followed by fruits served between 9-11 pm). A lot of time is spent not only on preparing food but also making sure that the house is spot clean, this is to make sure that if anyone shows up uninvited, then they will not be judged for having a messy house.

6. People often share food during lunch with visitors, leading to pressure to cook various food. I noticed that this culture had stayed the same since I left Iraq in 1999. People still turn up without notifying you about lunch. Lunch is the main meal; therefore, the expectation is that every household has prepared food.

7. Ordering food from outside is classed as you are well off, and almost 90% (based on my experience) use social media to inform others about food. This made me reflect whether this is because as a collective culture they care about being judged or is this the norm created since social media is used more often. Although I would

often hear the phrase *"I want others to know and make them jealous"* or *"I want others to know that I am having a good time"*.

8. When receiving visitors, it is the norm to serve a variety of snacks and drinks in order to be classified as a good host, and you must eat the foods offered to be perceived as a warm visitor. I realised that snacks and foods are purchased based on the luxury of the shops, the brand, and costs. The more luxurious, the better.

9. **Emotions:** Showing emotions or weakness means that you are unable to handle day-to-day life. The fear is of being labelled as weak. I noticed this was related to black-and-white thinking, mainly applied to mental health. You could be either *"normal or crazy"*. I asked one my aunties why she was not taking her depression medication prescribed by doctors; she replied, *"do you want others to think that I am crazy and do you want others to stop respecting me"*. Another lady had been through divorce and was struggling financially. She replied that it had not affected me mentally but referred to somatic symptoms. e.g., *"I can't focus for long periods due to my eyesight"*, even though her eyesight was fine.

10. We can't talk about emotions because it will shame the family, and people will see us as the problem. I realised this was particularly the case for families who were perceived as rich or involved in politics. Unfortunately, whilst being there, at least four women were shot dead due to honour-related issues and requesting divorce.

11. Physical sickness is normal to talk about. My family would often talk about their headache or pain in the body. I have never heard so many people mention that they fainted because of their headache or pain in their body. e.g., it appeared that this was used to gain sympathy from others as this would attract visitors and be looked after by family either through preparing meals for them or constantly phoning them. People would often visit doctors for minor physical issues such as headaches or stomach-ache and tell everyone about them during the gathering. However, throughout my six weeks, nobody talked about struggling mentally.

12. Expressing emotions is hindered because the person is often blamed for whatever had caused their unpleasant feelings. This was a significant barrier to expressing discomfort or issues. E.g., for those who have chosen to marry their husband, if the woman experienced difficulties in her marriage, she would feel reluctant to share because feeling sad or unhappy would be blamed on her.

13. When asking for a scale to weigh my bags to prepare for coming back to the UK, I asked about ten families and visited at least six shops, but I could not get a scale. This made me realise that BMI or Weight is likely difficult to monitor.

List of appendices for phase 2:

Quantitative phase appendices

Phase 2: appendixes

Qualitative phase appendices

Appendix I: Ethical approval for Phase two

UNIVERSITY OF WOLVERHAMPTON

Professor Damien Page BA (Hons) PGCE MA PhD
Dean of the Faculty of Education Health and Wellbeing
University of Wolverhampton
Millennium City Building
City Campus Wulfruna (South)
Wolverhampton
WV1 1LY
Telephone Codes
UK: 01902 Abroad: +44 1902

Switchboard: 321000

0822SAUOWPSY

3rd October 2022
S. Ahmed
University of Wolverhampton
FEHW

Dear Suha,

Re Piloting a culturally tailored emotional eating intervention for middle eastern women.

The Psychology ethics Deputy Chair has considered and reviewed your submission. On review your Research Proposal was passed and the Deputy Chair believes that the ethical issues inherent in your study have been adequately considered and addressed. Therefore the Chair is giving you full ethical approval for your study (**Code 1 - Approved**). We would like to wish you every success with the project.

Yours sincerely

[redacted]

Deputy Chair – Psychology Department Ethics Panel
Senior Lecturer in Applied Psychology
Department of Psychology

Appendix J: Recruitment poster for phase 2 (pilot intervention)

Would you like to better understand and manage your emotional eating?

Start date:
Session 1: 12/10/2022
Session 2:19/10/2022
Session 3:26/10/2022
Session 4:02/11/2022
From: 11 to 1 PM

Address:
288 Camden street
Birmingham
B18 7PW

You may be suitable to take part in a 4 week self-help programme if:

- ✓ You live in the UK
- ✓ You are aged 18+
- ✓ You identify emotional eating as a problem and would like to reduce this
- ✓ You are from one of the following middle eastern countries:

Iraq/Kurdish, Egypt, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, United Arab Emirates, Yemen, Israel, Iran and Turkey.

Why get involved?

- The programme is designed for middle eastern women taking into consideration cultural factors that may influence emotional eating
- You will learn how your emotions can influence your eating behaviours
- You will learn to identify your own emotional eating triggers
- You will be provided with resources and support to manage your emotions in other ways

What is involved?

- The 4 week programme is delivered through face-to-face group support sessions and simple independent reflection tasks
- Weekly group session will last no more than 3 hours
- On completion you will complete a programme evaluation questionnaire so we can identify what works well and what to improve

If you are interested in taking part or would like to know more, please contact:

Suha Ahmed
Doctorate trainee in counselling psychology
Email: [redacted]

Appendix K: Participant information sheet

Title of the study:
Piloting a culturally tailored EE intervention for Middle Eastern women.

Who is conducting the study?
The research will be conducted by Suha Ahmed a Counselling psychologist in training at The University of Wolverhampton.

What is the study about?
This study aims to pilot and evaluate a culturally adapted EE intervention intended to increase awareness of EE and support you to manage this using different strategies. Please read this document carefully and feel free to ask any questions if you would like more information.

Why am I being invited to take participate?
The current research is looking to recruit Middle Eastern women who have identified that emotions influence their eating habits, and they wish to manage this better. It is not appropriate to participate in this research if you identify with an eating disorder or are diagnosed with an eating disorder, as this requires a very different approach to treatment and intervention.
If you self-identify with the ethnic heritage of the following Middle Eastern countries: Egypt, the Arab countries of Asia (Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, United Arab Emirates, Yemen), Israel, Turkey, and Iran then you are invited to participate in this study.

What will taking part involve?
Taking part in the study involves the following:

Duration: you are invited to take part in one session per week lasting approximately three hours (including breaks). The program will last four weeks.

Time: The sessions will run from 11am until 1pm every Wednesday.

Start date: (to be confirmed)

Address: The sessions will take place within the Happy Family community centre. Address: 290 Camden Street, Birmingham B18 7PW.

Program information:
Session one: Ice breaker and psychoeducation

- Complete a questionnaire: During and after the session you will be asked to complete) a set of questions to help with the evaluation of the intervention. Please note that this can be done during the session (time will be allocated) or in your own time.
- Discussing group contract including confidentiality.
- Reminding you about what the intervention will include and what to expect.
- Introducing you to CBT which help you to understand the connection between the mind and the body.
- Information on common eating problems will be shared such as binge eating disorder.
- You will be encouraged to set personalised and specific goals.
- Homework: You will be provided with a self-monitoring worksheet which will allow you to monitor your triggers, emotions, physical symptom, and the impact on your eating.

Session two: Education and Problem-solving

- The session will start with reviewing Homework. You will have the opportunity to share you experience with the rest of the group.
- Cultural beliefs and values will be explored and its impact on EE.
- You will be introduced to Problem-solving techniques other than using food to regulate your emotions.
- Homework: Monitoring your problem-solving.

Session three: Managing unhelpful thinking and mood regulation.

- Review homework
- Cognitive errors (which refers to when your thoughts and reality don't match up, often without you even realising) such as black and white thinking (all or nothing), overgeneralising will be explored. You will be provided with a handout which has common cognitive errors included.
- Mood acceptance: education about moods and acting on moods.
- Homework: Practice the use of functional mood modulatory behaviour.

Session four: Maintenance plan and continuity

- Review of homework
- Identify potential barriers and discuss a maintenance plan.
- Complete post-intervention scales (appendix M) and open questionnaires evaluating intervention experience in order to address the research questions.
- Finally, you will be provided with a self-help booklet which contains information to reinforce what you have learned during the group sessions and support the ongoing management of emotional eating.

Do you have to take part?
No, your participation is voluntary.

What if I want to drop out?
If you wish to drop out at any stage during the intervention, then please just let me know. If you wish to withdraw your data, you can do this, without any impending consequences up to two weeks following taking part in the intervention. This can be done by contacting the researcher on the details provided below.

What if I do not want you to include certain things I have said in my intervention?
If during the intervention you say something which you decide you do not want to be included, then please just say during the intervention that you would like it omitted from the analysis and the completed report. Alternatively, you have up to two weeks after the intervention to inform me about any information you would like removed.

What if I am upset by anything during the study?
If this happens, you might like to take a break, or if you prefer, you can decide to end your participation and withdraw from the study at that point. If you decide to withdraw, I will provide you with a copy of the debriefing sheet. [The debriefing sheet contains information about sources of support you can access if there is anything you wish to talk about in confidence].

Who will have access to the recording / raw data?
Only the researcher and the researcher's supervisors will have access to the recording and raw data.

Who will have access to questionnaire data? The researcher and the researcher's supervisors. Please be aware that your personal information will have been removed such as your name before allowing supervisors to have access to your data.

Who will see the finished report?
Anonymised extracts from your interview data may be included in the finished report. This will may mean that the transcript and final report will be seen by the researcher's supervisors and a second marker from the Psychology department and possibly by an external examiner.

What will happen to my information collected during the intervention?
All data will be kept in secure storage (to which only the researcher has access) for five years and will be destroyed after that, according to departmental policy.

Who has approved this study?
Approval for this study has been granted by The University of Wolverhampton, Division of Psychology Ethics Committee.

If you wish to raise concerns regarding research being undertaken by the University, you may wish to contact the research integrity leads in the first instance.
The senior lead for research integrity is the Dean of Research - Professor Silke Machold
The administrative lead is the Research Integrity Manager - Miss Jill Morgan

Is there anyone I can talk to about the study before I take part?
You are welcome to contact me (Suha Ahmed) if you have any question about the study using the e-mail contact provided below. Alternatively, if you wish to talk to someone else about the study before taking part, then please feel free to contact my project supervisors using the contact details provided at the end of the information sheet.

I know a friend who may be interested; can she participate in your study?
Yes, certainly if your friend meets the criteria mentioned above. Your friend can contact me directly to discuss the study.

Are there any specific services I can contact to get help?
Yes, please find the details below:
BEAT (eating disorder service)
Helpline: 0808 801 0677
Student line: 0808 801 0811
Youth line: 0808 801 0711

IAPT Birmingham (Participants will be informed about other IAPT services within their city). 0121 3012525

SAMARITANS:
Tel: 116 123 or Email: [e-mail address redacted]

Thank you for your time and if you decide you would like to participate in my study, please contact me.
My contact details are as follows:
Researchers contact details:

Suha Ahmed **Emal:** [e-mail address redacted]

Supervisors contact details:

Prof Tracey Devonport **Email**: [e-mail address redacted]

Dr Jennifer Lim **Email**: [e-mail address redacted]

Dr Gurpinder Lalli **Email:** [e-mail address redacted]

Thank you.

Appendix I: Participant consent form

Researcher name:
Suha Ahmed
Researcher Contact
[e-mail address redacted] or [number redacted]
Chosen participant pseudonym (false name)

---

*Please read the following items carefully and **write your initials or a tick in the box** to indicate that you have read, understood and agreed with each item.*

I am over 18 years of age and voluntarily agree to take part in this study. ☐

I have read the information sheet and understand that this study is conducted. as part of a doctoral thesis project. ☐

I understand that I will take part in a group intervention lasting approximately. 3 hours per week over four consecutive weeks. I will be asked to respond. to a series of questions regarding emotional eating. ☐

The purpose and nature of the study has been clearly explained to me and I have. been given the opportunity to ask any question about the study. ☐

I understand that the intervention is with a group of other Middle Eastern ladies. This means that any information shared during the group sessions should remain. confidential. I am therefore not allowed to discuss this with anyone outside the Group. ☐

I understand that I will not benefit directly from participation in this study. ☐

I understand that my data will be fully protected following. the Data Protection Act of 1998, and in compliance with the British Psychological Society ethical guidelines, and that my data will be kept confidential and anonymous until they are securely destroyed. ☐

I understand that my name and any personal details will be anonymised. This will be done using numbers or pseudo names. ☐

I agree that any of the data I provide will be used for the thesis project and possibly used for publication in academic journals. ☐

I understand that in case the data are used for publication, they will be. kept until five years after the article has been published, and then destroyed. ☐

I understand that disguised extracts from my intervention may be quoted in the Writing up of the thesis or journal article for publication. ☐

I understand that if I inform the researcher that I or someone else is at risk. of harm, they may have to report this to relevant authorities. They will discuss. this with me, but it may require doing this without my permission. ☐

Signature of researcher: **Signature of participant**

---------- **----------**

Date: **Date:**

Appendix L: Participants Debrief from

I would like to thank you again for your participation in the second phase of the present study '**Piloting a culturally adapted intervention to manage emotional eating'** which involved taking part in four group sessions, one per week for four weeks, to manage emotional eating.

If you have experienced any psychological difficulties from taking part in this study, please contact me or any of the supervisors who are listed below. If you feel uncomfortable contacting us, then please contact your GP or any available counselling service. Please be reminded that your data will be kept confidential and completely anonymous. In case of the data being used for academic publication, transcripts will be kept for five years from the date of publication.

Please make a note of your participant pseudonym. If you wish to withdraw your data you need to contact the researcher using the contact details below and quote your participant pseudonym, before *01/10/2022*. No other information is required, and you will not be asked to provide a reason.

If you require additional information, please do not hesitate to contact me or my supervisors.

Thank you again for your participation.

Researchers contact details:
Suha Ahmed **Email:** [e-mail address redacted]

Supervisors contact details:

Prof Tracey Devonport **Email**: [e-mail address redacted]

Dr Jennifer Lim **Email**: [e-mail address redacted]

Dr Gurpinder Lalli **Email:** [e-mail address redacted]

Appendix M: Data collection Questionnaire used for phase 2.

<table>
<tr><td>Pre-intervention Measures (Quantitative)</td><td>Question 1: On a scale of 1-5 (1 = low, 5 = high) how motivated are you to change your emotional eating?
0 1 2 3 4 5
Question 2: On a scale of 1-5 (1 = low, 5 = high) how confident are you that you can change your emotional eating?
0 1 2 3 4 5

and
The modified subscale of the Dutch Eating behaviour questionnaire (Bailly et al., 2012). The questions used are listed below.

1. Do you have the desire to eat when irritated?
2. Do you have the desire to eat when something unpleasant is about to happen?
3. Do you have desire to eat when feeling lonely?
4. Do you have desire to eat when depressed or discouraged?
5. Do you have the desire to eat when things go wrong?
6. Do you have the desire to eat when emotionally upset?</td></tr>
<tr><td>Post-intervention measures (Quantitative)</td><td>Question 1: On a scale of 1-5 (1 = low, 5 = high) how confident are you that your EE has changed?
• 0 1 2 3 4 5

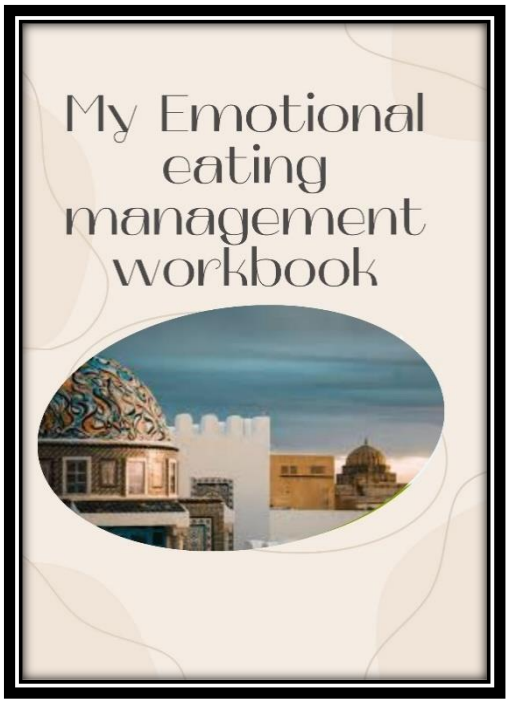
Question 2: On a scale of 1-5 (1 = low, 5 = high) how confident are you that you can maintain changes to your emotional eating?
• 0 1 2 3 4 5

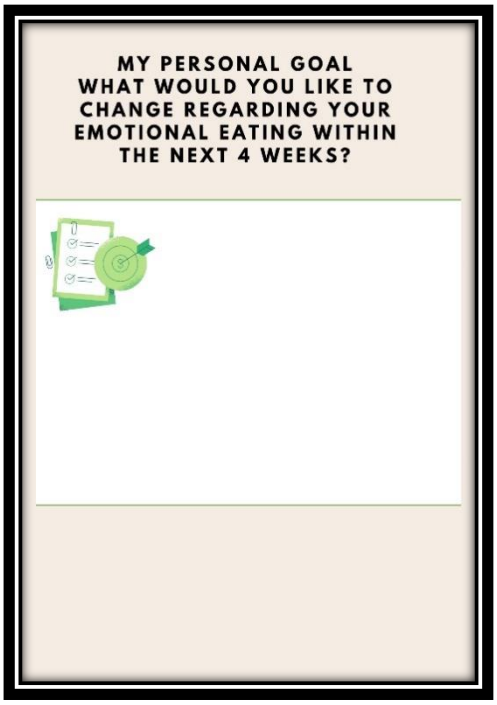
and
The modified subscale of the Dutch Eating behaviour questionnaire (Bailly et al., 2012).</td></tr>
<tr><td>Post-intervention questions for the intervention group (Qualitative)</td><td>Semi-structured open-ended questionnaire

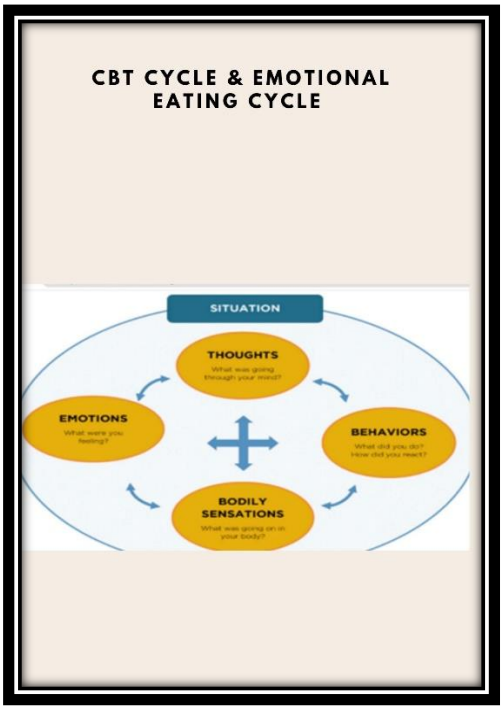
• Now you have completed all four workshops, what has your overall experience of them been?
• Were some aspects more helpful than others? If so, what did you find most helpful and why?
• What if any aspect did you find less helpful or more challenging?
• Did you find it easy to understand the workshop and homework content?
• To what extent did the workshops and homework accommodate your cultural and religious needs?
• What would you like to have seen more of?
• What changes, if any, have you noticed as a result of taking part in these workshops?
• Do you feel that you understand your EE better? If so, how?</td></tr>
</table>

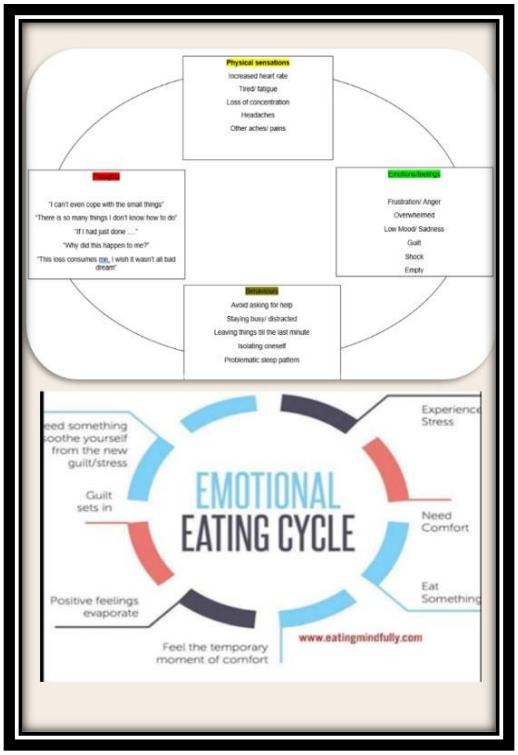
Appendix N: Indicative Worksheets

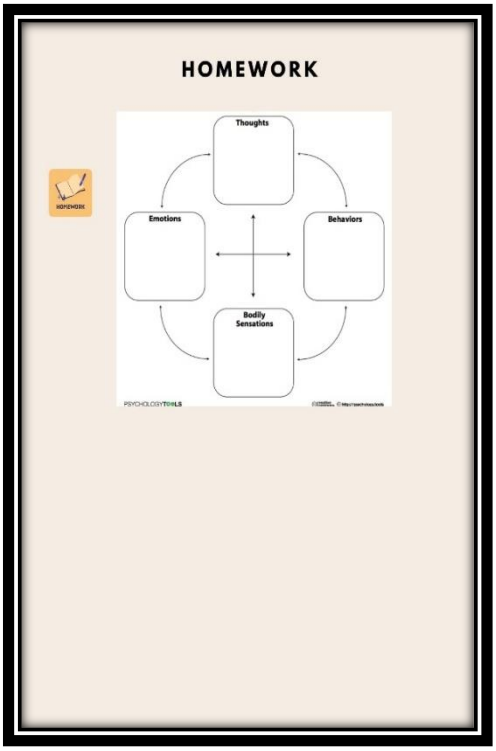
Cognitive Behavioural Therapy (CBT) Skills Workbook Pack
For managing Emotional Eating
This pack contains:





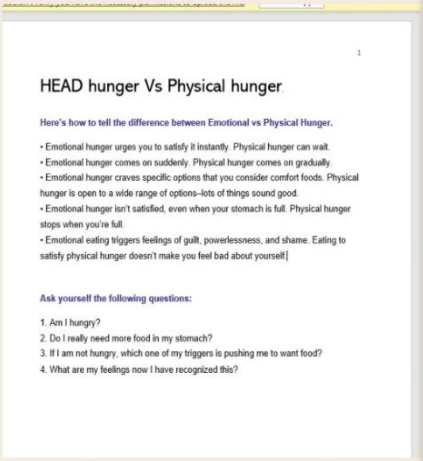






COGNITIVE DISTORTIONS

HEAD HUNGER VS PHYSICAL HUNGER.



HEAD hunger Vs Physical hunger

Here's how to tell the difference between Emotional vs Physical Hunger.

- Emotional hunger urges you to satisfy it instantly. Physical hunger can wait.
- Emotional hunger comes on suddenly. Physical hunger comes on gradually.
- Emotional hunger craves specific options that you consider comfort foods. Physical hunger is open to a wide range of options–lots of things sound good.
- Emotional hunger isn't satisfied, even when your stomach is full. Physical hunger stops when you're full.
- Emotional eating triggers feelings of guilt, powerlessness, and shame. Eating to satisfy physical hunger doesn't make you feel bad about yourself.

Ask yourself the following questions:

1. Am I hungry?
2. Do I really need more food in my stomach?
3. If I am not hungry, which one of my triggers is pushing me to want food?
4. What are my feelings now I have recognized this?

REGULAR EATING

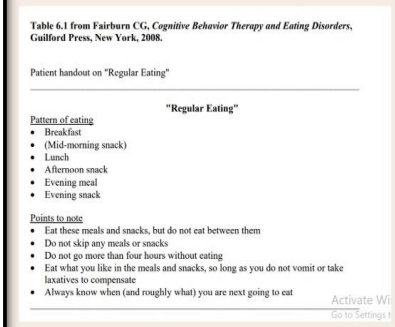


Table 6.1 from Fairburn CG, *Cognitive Behavior Therapy and Eating Disorders*, Guilford Press, New York, 2008.

Patient handout on "Regular Eating"

"Regular Eating"

Pattern of eating

- Breakfast
- (Mid-morning snack)
- Lunch
- Afternoon snack
- Evening meal
- Evening snack

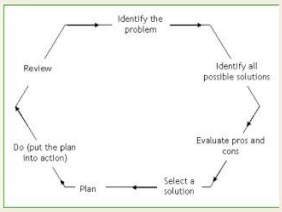
Points to note

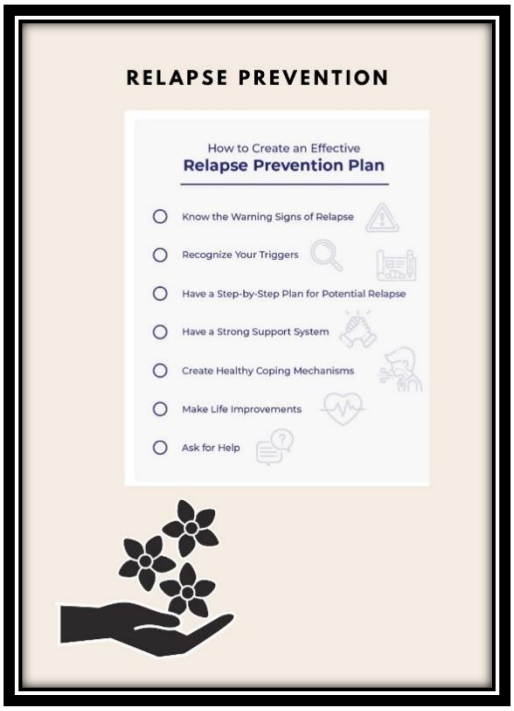
- Eat these meals and snacks, but do not eat between them
- Do not skip any meals or snacks
- Do not go more than four hours without eating
- Eat what you like in the meals and snacks, so long as you do not vomit or take laxatives to compensate
- Always know when (and roughly what) you are next going to eat

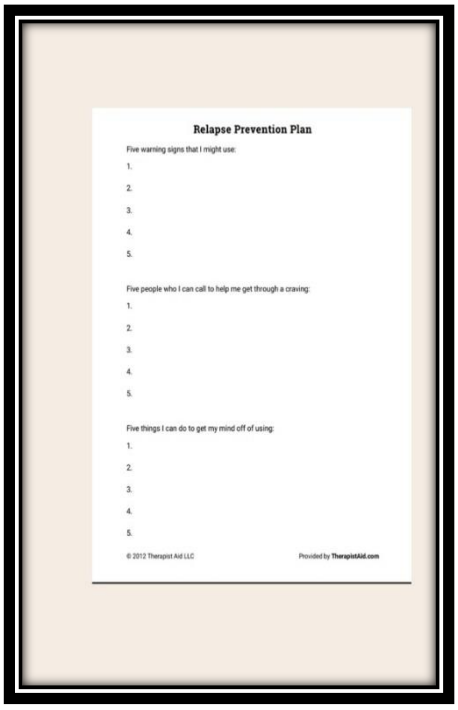
Time	Food Preparation/Amount	Degree of Hunger (Most hungry 10=ravenous	Emotions Happy, sad, bored, stressed, angry, frustrated, nervous, etc.	Where-place/room	People I am with when eating	Activity Sitting, standing, driving, reading

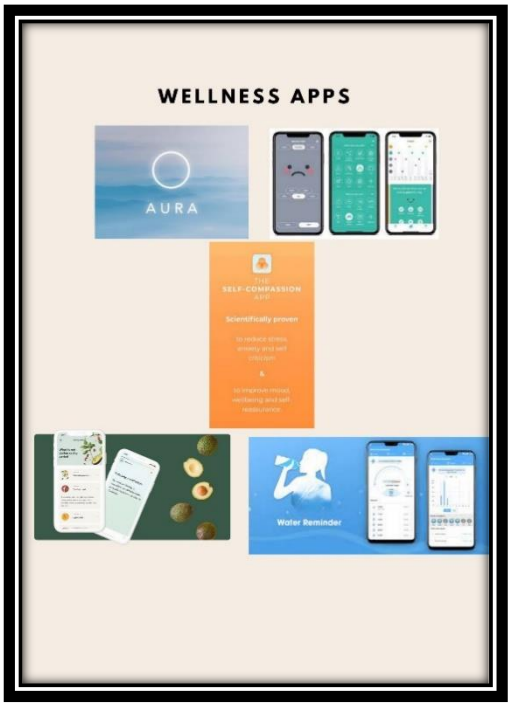
PROBLEM SOLVING

MOOD ACCEPTANCE AND ACTING THE OPPOSITE




RELAPSE PREVENTION
How to Create an Effective
Relapse Prevention Plan
Know the Warning Signs of Relapse
Recognize Your Triggers
Have a Step-by-Step Plan for Potential Relapse
Have a Strong Support System
Create Healthy Coping Mechanisms
Make Life Improvements
Ask for Help


Relapse Prevention Plan
Five warning signs that I might use:
1.
2.
3.
4.
5.
Five people who I can call to help me get through a craving:
1.
2.
3.
4.
5.
Five things I can do to get my mind off of using:
1.
2.
3.
4.
5.
© 2012 Therapist Aid LLC
Provided by TherapistAid.com


WELLNESS APPS
AURA
Scientifically proven
Water Reminder

Appendix O: Note to self-based on feedback received from participants at the end of the sessions.

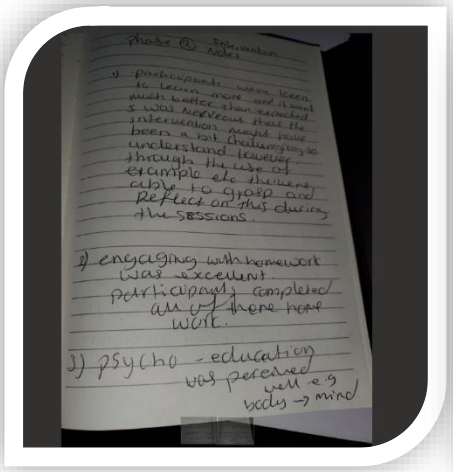
- The session went better than expected. They appear to engage really well and keen to learn more.
- It appeared that EE meant eating in response to negative emotions, when educated about pleasant emotions the response was, I had not thought about that.
- Sharing distorted thoughts was really well received and they stated that it makes sense now and enjoyed exploring this as a group and talking about this using their experience. They also share how their culture norms and values were leading or causing these thoughts e.g. expectation of women, feeling responsible even though it was not their responsibility. Fortune telling was the main one for the women. E.g. things will go bad.
- The hot cross bun was also well received, and it appeared that they had not thoughts about the connection between the mind and the body and physical symptoms.
- The found the thought record a bit challenging to understand and we therefore went through this using example. Which was helpful?
- Finally, they felt ready to engage in the homework and they did complete their homework each week.

Challenges:

- bringing participants back together following breaks
- some participants were interruptive when others were sharing due to wanting for their experience and voice to be heard.
- At times participants would deviate from the topics.
- Couple of times participants would ask each other or myself personal stuff, which had to be managed sensitively.

Feedback:

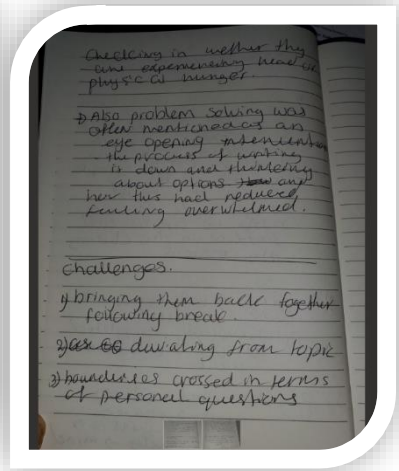
- One said when I came in, I didn't think I would benefit so much from this.
- Another shared it so nice to talk about this with others who feel the same.
- Another said I have not realised how much of black and white thinking I engaged in
- Another one said I like the method of delivery it was simple, understandable and easy to follow.


Phase 2 Intervention Notes

1) participants seem keen to learn more and about s was nervous that the intervention might have been a bit challenging to understand however through the use of example etc they were able to grasp and reflect on this during the sessions.

2) engaging with homework was excellent. participants completed all of there home work.

3) psycho-education was perceived well e.g body → mind


checking in wether they are experiencing head or physical hunger.

Also problem solving was often mentioned as an eye opening intervention the process of writing it down and thinking about options ~~how~~ and how this had reduced feeling overwhelmed.

challenges.

1) bringing them back together following break.

2) ~~ex~~ ~~co~~ distracting from topic

3) boundaries crossed in terms of personal questions

Appendix P: journal article of phase 1

To be published in: Springer (International Journal for the Advancement of Counselling).

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