A qualitative exploration of the experiences of an Intuitive Eating (IE) intervention during COVID-19

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

This qualitative thesis explores the experiences of women undertaking an Intuitive Eating (IE) intervention for disordered eating during COVID-19. The study is the first to examine experiences of an IE intervention during a pandemic, contributing to the scant qualitative IE research base and providing novel insights.

Part one is a Conceptual Introduction which addresses the essential theoretic and research underpinnings of the IE framework. Further, it reviews the evidence surrounding weight loss, dieting and weight stigma which align with the cornerstone principle of the IE framework, *Rejecting the Diet Mentality*. Gaps in the literature are identified and a rationale provided for the empirical paper.

Part two, the empirical paper, is a qualitative thematic analysis of 11 participants' experiences of IE treatment during COVID-19. Semi-structured interviews were conducted and five overarching domains were identified from the data: The identified domains were life-altering, a process of self-exploration, finding liberation through lockdown, the challenges of COVID and 'not operating in a vacuum'. Results suggest overall favourable experiences of the IE model in the sample and highlighted specific facilitators and barriers to IE, as well as discussing societal impacts on IE treatment.

Part three is a critical appraisal of the research process which provides reflections on preliminary research stages and the impact of COVID-19, as well as the recruitment and sampling, interview and analysis stages of the research. It also includes an expanded discussion of the strengths and limitations of the empirical paper and directions for future research.

Impact statement

The present study has generated results which bring to light possible research, clinical and societal implications. New insights have been generated into the experiences of those undertaking an Intuitive Eating intervention, specifically during COVID-19, adding to the sparse evidence base on the impact and experiences of IE. Through utilizing inductive thematic methods, a depth of understanding of the sample, including the specific impacts of the pandemic on IE treatment was achieved which would have been inaccessible through quantitative methods alone. There are plans to publish the present study in a peer reviewed journal in order to disseminate findings to the academic community and IE practitioners. It is hoped that the present research generates further interest within the research community, particularly in the UK where very limited IE research has been conducted.

Notwithstanding the small scope of the present study, it is hoped that through highlighting the experiences of IE treatment in this sample that the research is adding to a growing body of evidence which may lead to interest in larger scale studies of IE as a treatment for disordered eating. Building on preliminary work conducted in the United States, further avenues of research could be explored both clinically (e.g. with adolescents, group programmes) or in varied sectors. For example, sessions on specific aspects of IE, such as the impacts of diet culture and weight-stigma could be trialed as stand-alone PSHE sessions in secondary schools, alongside the group and guided self-help interventions already being piloted in universities in the United States.

Participants' multiple accounts of fears of gaining weight and judgement from others highlight the continued cultural context of weight stigma and its adverse effects. It is hoped that the present research identifies the need for societal attitudes and behaviours towards those in larger bodies to be scrutinized and wider dissemination of anti-weight stigma, IE and Health at Every Size (HAES)-related material be prioritized by policy and health care providers. Further, it highlights the potential negative impacts of public health strategies,

such as the UK's Tackling Obesity (August 2020) campaign on both those in larger bodies and those at risk of developing disordered eating or eating disorders.

Table of Contents

List of Appendices

List of Tables and Figures

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Part 1: Literature Review

A Conceptual Introduction: Intuitive Eating and anti-diet approaches to health

Abstract

Intuitive Eating (IE) is a non-diet approach and treatment for disordered eating (Tribole & Resch, 2020). The IE framework covers ten principles to develop a healthy relationship with food, mind and body and is gaining international attention. The current research base is showing both promising and more established benefits to psychological and physical health. Long-term benefits and experiences of more diverse populations are beginning to be evidenced but further research is required to add to the breadth and depth of current findings.

There are a number of negative health consequences that have been associated with overweight and obesity; in order to mitigate these risks, dieting and increases in physical activity expenditure are frontline treatments for weight-loss. However, the evidence base for the ineffectiveness and harms of dieting are robust, such as physical outcomes of long-term weight gain and psychological increases in risk, such as for eating disorders. These serious psychological and physical harms pose a risk to dieters and alternative interventions to support health are required. Intuitive Eating and its anti-diet stance challenge the notion that weight loss in and of itself should be a goal for increased health. Further, there are specific cultural and contextual factors that affect experiences of weight. This conceptual review provides an overview of the essential research and theoretical background underpinning the IE framework including the evidence behind the anti-diet approach to weight and health. Given the novel status of Intuitive Eating and anti-diet approaches to health in the UK, this conceptual review fills the gap in knowledge on these concepts and the evidence behind them.

Introduction

This introduction will present the theory and research underpinning both dieting for weight loss and the anti-diet approach to wellness, a central component of the Intuitive Eating philosophy. Cultural and contextual effects on experiences of weight will also be discussed. This section will provide context to the Intuitive Eating approach, described later in the paper.

Evidence in support of dieting

It is currently estimated that around 1.9 billion adults worldwide are classified as overweight or obese (Jensen et al., 2014). In the UK it is estimated that around 63% of adults fall into this category (Tackling Obesity, August 2020). Associations with weight have been found to correlate with a number of negative health outcomes. For example, increases in risk of stroke, heart disease, type 2 diabetes, cancers, liver and respiratory diseases have been identified (Guh et al., 2009). In the current context of a pandemic there have been specific concerns about the increased risks linked with overweight status and mortality from COVID-19 (Senthilingam, 2021). Additionally, living in a larger body can affect quality of life for some, with activities of daily living such as accessing workplaces or transport more challenging (Ilvig & Christensen, 2017) and associations with increased risk of depression identified (Luppino et al., 2010). Importantly, overweight individuals are also affected by social discrimination and weight stigma which have been found to have a significant impact on psychological and physical outcomes as well as overall quality of life, and brings into question the role of weight stigma as a potential moderator in associations directly linked at present to higher weight (Puhl & Heuer, 2010; Tomiyama, 2014).

Public health institutions and governments in addition to a vast number of individuals with overweight status want effective strategies for weight control in order to mitigate associated negative health outcomes and healthcare costs (Tackling Obesity, August 2020). At present, dietary restraint, i.e. dieting, and increased physical activity in order to create a

calorie deficit are the first line treatment for weight loss (Hartmann-Boyce et al., 2014). The mode of treatment can vary greatly but can include commercial weight loss programs such as Weight Watchers or Slimming World which have been contracted for use by NHS trusts due to better outcomes when compared with primary care-based services (Jolly et al., 2011). Most programs however will utilize self-monitoring (such as calorie counting) and behavioural planning such as goal and action setting (Teixeira & Marques, 2017). Although it is possible to reduce weight in the short-term through dieting, with some experiencing some success with weight maintenance up to two years, there is very limited evidence beyond that to date (Dombrowski et al., 2014; Ramage et al., 2014).

Importantly, the most successful weight-loss programs are those that provide intensive, individualized and long-term support to participants (Dombrowski et al., 2014), unsurprising given the myriad challenges individuals face with sustained behavioural change (Jessen-Winge et al., 2021). Behaviour change techniques, or the active and observable behaviours that can be undertaken for weight loss, appear to be the most effective element of weight loss programmes when undertaken in conjunction with adequate support (Drombrowski et al., 2014; Michie et al., 2009). For example, prompt and supported goal setting and self-monitoring can be employed with individuals, as well as techniques addressed systemically by services such as provision of fitness classes to make changes to the individuals' social environment (Michie et al., 2009). Although at present the evidence for utilising one behavioural change technique over another for weight maintenance is limited, the factor that appears to make the most impact in behavioural interventions is the provision of extended care and support for individuals (Middleton, Patidar & Perri, 2011).

In conclusion, negative health consequences have been associated with overweight and obesity. In order to mitigate these risks, dieting and increases in physical activity expenditure are frontline treatments for weight-loss. Weight-loss programs can work in the short-term but there is significant evidence that they do not work for many long-term. In addition, intensive treatments can be required in order to effect significant behavioural and

lifestyle change, although supported behavioural change techniques have shown small but significant effects for weight loss maintenance (Dombrowski et al., 2014).

Ineffectiveness of dieting

Simultaneously, there is a significant body of evidence indicating that diets and weight-loss programs are ineffective and lead to weight gain overall. As far back as the 1950s, literature has shown that sustained and permanent weight loss, particularly for those in the 'clinical' weight range, is rarely possible (Rothblum, 2018). Rather than leading to sustained weight loss, dieting is paradoxically one of the strongest, well-established and consistent predictors of weight gain in the long-term, as well as being associated with significant harms and poor mental health (Mann et al., 2007; O'Hara & Taylor, 2018; Solmi et al., 2020). For example, the twin study by Pietiläinen et al. (2012) found that dieting led to weight gain, independent of genetic factors. Statistically speaking between one to two thirds of those who lose weight regain it within a year, with almost all weight regained within five years (NIH Technology Assessment Conference Panel, 1992). In experimental studies of weight loss dieters did not show significant differences two years later in weight lost when compared to a control group of non-dieters (Mann et al., 2007; Tomiyama et al., 2013). Fildes et al. (2015) followed over 150,000 obese individuals over a span of nine years in the UK and found that weight loss retention was rare and losing enough weight to be categorised within a "normal" weight range was extremely rare. Additionally weight cycling, or the process of gaining and losing weight in a cyclical fashion was common, particularly for people with a BMI over 40. These 'yo-yo' effects are understandable considering the vast majority of dieters gain back more weight than they initially lose on the diet over time (Mann et al., 2007).

There are significant biological reasons why weight loss attempts do not produce the desired results. Although behaviour, environment and genetics play an inter-related role in weight outcomes, research has indicated that Body Mass Index (BMI) is between 40-70% heritable (i.e. determined by genetic factors), with less variance determined by

'environmental' impacts than may be commonly assumed (Farooqi & O'Rahilly, 2006; Loos & Yeo, 2021; Stunkard et al., 1990). It is also recognized that we have an individualised 'set point weight' at which our bodies function optimally and that our bodies will try to maintain through metabolic processes (Müller et al., 2010; Speakman et al., 2011; Yu et al., 2015). Further, there is mounting evidence to suggest that associations between BMI and adverse health outcomes found in many obesity studies may be at least partly due to other confounding factors. Although studies have linked higher BMI with an increased risk of disease, none have in fact identified weight as the *primary causal factor* in the relationship (Hunger et al., 2020). For example, Klein (2004) found no change in measured health markers following participant large-volume liposuction, adding to the hypothesis that confounding variables likely impact the relationship between weight and health. Third variables and/or reverse causations should therefore be considered as potential factors affecting the relationship between weight and poor health (Hunger et al., 2020). Emerging evidence has identified lack of movement (Ortega et al., 2012), metabolic dysfunction (Pennings, 2018), weight cycling (O'Hara & Taylor, 2018) and stress (Tomiyama, 2019) amongst the possible mechanisms underpinning this relationship.

Harms of dieting

Dieting practices can also cause significant harm, such as a preoccupation with food and body, reduced self-esteem and the development of eating disorders (Bacon & Aphramor, 2011). As knowledge is gained around the impacts of dieting on individual psychology and health, research into these experiences is expanding. For example, the psychological impacts of dieting have been identified as increased rates of anxiety, depression, preoccupation with food, irritability, apathy and negative body image, and eating more in response to these negative emotional states than non-dieters (Canetti et al., 2002).

There are other specific psychological responses to dieting that have been studied. Urbszat et al. (2002) investigated the effects of anticipatory restriction on eating behaviour. They found that participants allocated to a group who were told they had to diet for the next

week ate significantly more in a task than ‘unrestrained’ eaters who were assigned to the non-diet group. This anticipation of food deprivation, also known as the ‘last supper effect’, is a common phenomenon experienced by dieters. Importantly, the anticipation and effects of dieting create a ‘binge and restrict’ mentality, as seen in Figure 1. Therefore the psychological impact of engaging with diets, even pre-restriction, has a significant effect on eating behaviour and cognition around food.

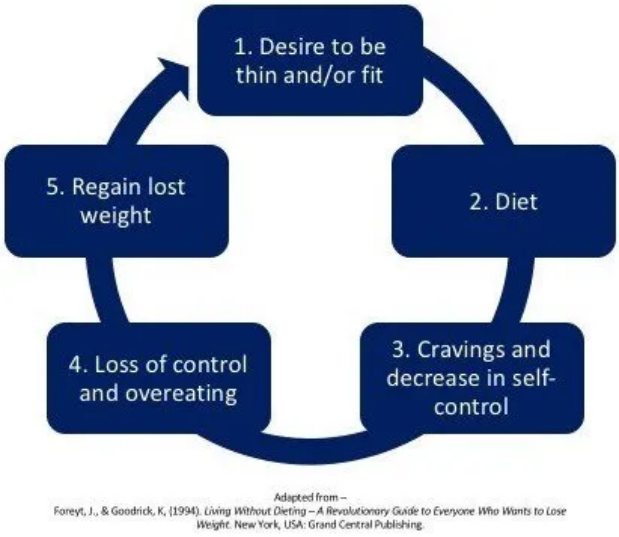

Figure 1: The dilemma of dieting (Foreyt, 1994).

The literature indicates that early dieting practices and the development of disordered eating can have lifelong consequences. Enriquez et al. (2013) conducted a twin study with 950 women to ascertain whether early age at dieting onset was associated with higher BMI and disordered eating practices. Earlier dieting (with some participants reporting dieting from the age of eight years old) was associated with a higher BMI, food restraint, risky dieting behaviours and increased weight cycling. Longitudinal studies of dieting indicate that 35% of so called ‘normal’ dieters transition to disordered eating, with 30–45% of those dieters progressing to clinical eating disorders (Shisslak et al., 1995).

Disordered eating can be categorized as clinical or sub-clinical and involves a number of behavioural (e.g. food restriction, skipping meals, over-eating, binge eating, fasting) and psychological experiences (negative mood states such as shame, guilt, anxiety or distress) (Thomas, 2019). Sub-clinical disordered eating is common amongst Western cultures, estimated to affect 50-75% of women (Carolina Public Health, 2008). In the UK, sampling evidence has indicated rates of disordered eating to be around 41% in 16-year-olds, 11% of whom met diagnostic criteria for eating disorders (Bould et al., 2018). In a longitudinal study of 1,491 adolescents over half of all participants engaged in weight control behaviours, including skipping meals, fasting, taking diet pills, using laxatives and food substitutes (Hazzard et al., 2020). This is particularly worrying given that Patton et al. (1999) identified dieting as the most important predictor of new eating disorders in adolescents. Dieting is therefore particularly detrimental for adolescents, leaving them susceptible to the development of eating disorders as well as the broad psychological and physical harms of disordered eating and dieting.

In addition to the negative psychological impacts of the diet cycle, significant physical health implications can result from weight cycling which is extremely common in dieters. It has been associated with a number of chronic, harmful health outcomes including higher mortality, cardiovascular disease, fracture risk, inflammation, type 2 diabetes, hypertension and suppression of immune function (Bacon & Aphramor, 2011; O'Hara & Taylor, 2018). Of note, many of these physical health outcomes are typically connected with an individual's higher weight and weight cycling is rarely controlled for as a mediator in studies of the relationship between weight and physical health difficulties. There is evidence that 'yo-yo dieting' in and of itself mechanistically results in increasing weight-set-point due to the complex internal biological and hormonal imperatives to ensure physical survival (Chhabra et al., 2016; Rosenbaum & Leibel, 2014; Strohacker et al., 2009). Further, individuals who have lost 10% or more of their body weight show metabolic dysfunction, burning significantly fewer calories than average based on weight and body composition (Rosenbaum et al.,

2010). The body is effectively working to regain stasis and weight set point, a 'biological opposition', mediated by hormones which affect hunger signals such as leptin. It can therefore in fact be physiologically harmful to focus on weight-loss (rather than improved *health*) as a goal for treatment.

In closing, the evidence base for the ineffectiveness and harms of dieting are robust. Dieting programs are ineffective and lead to weight gain and have been found to increase the risk of eating disorders, binge eating, weight cycling, food preoccupation, body dissatisfaction, weight stigma, depression and anxiety (Bacon & Aphramor, 2011; Canetti et al., 2002; Enriquez et al., 2013; Urbszat et al., 2002). Further, there are risks from weight loss including those associated with weight cycling and metabolic dysfunction (Bacon & Aphramor, 2011; Rosenbaum et al., 2010). These serious psychological and physical harms pose a risk to dieters.

Cultural context of diet and wellness culture

The Intuitive Eating model was created in response to the failures and harms of diets at supporting overall wellbeing. The wider diet culture industry distributes and monetizes the message that weight is the lens through which a person's attractiveness, health, fitness, status and even their 'goodness' or moral supremacy are to be judged (Low et al., 2003). Those who struggle to embody thinness can therefore spend a lot of money, time, psychological and physical energy in its pursuit. The control of food and exercise through monetized programs are therefore central to diet culture. From a business perspective, fostering a preoccupation and anxiety around food can support 'repeat purchase' of products or diet plans, keeping the public focused on engaging with their product and propping up the multi-billion pound diet industry (Garner & Wooley, 1991). As highly restrictive diets are unsustainable, people can spend their lives cycling through diets, chastising themselves and feeling de-valued for their inability to obtain and/or sustain weight loss whilst the diet industry profits (Bacon & Aphramor, 2011; Kassirer & Angell, 1998).

It could be argued that the modern iteration of the traditional diet is a focus on wellness. In the pursuit of optimum physical health the culture of diets has remained, seen through approaches such as gluten-free eating or eliminating food groups (where these are not medically indicated), 'clean' eating, detoxes, juice cleanses and refined sugar free diets. What many of these approaches have in common is a structure of morality around food – some are deemed 'good', 'pure' or 'clean' and some 'bad', and people should follow these often extreme food rules in order to protect or optimise health. Further, wellness culture is often perpetuated by those with the means to adhere to restrictive lifestyles which are often expensive and time consuming, further alienating those without access to these protocols.

The pursuit of wellness can come at the expense of psychological and physical wellbeing. At its extreme engaging with wellness trends can lead to the development of eating disorders such as Orthorexia, a type of disordered eating where an individual has an obsession with only eating 'pure', 'clean' or 'healthy' foods (Scarff, 2017). Orthorexia can result, amongst other outcomes, in malnourishment, isolation, poor quality of life, anxiety, depression and cognitive rigidity, and has even been reported as a prodrome for schizophrenia (Koven & Abry, 2015; Saddichha et al., 2012). The narrow focus on food as a primary driver of wellbeing, promoted through diet culture and propelled by slogans such as "you are what you eat" or "food is medicine", can have serious consequences for individuals' lives. McGovern et al. (2021) collected qualitative data from recovered orthorexics where participants described orthorexia emerging from dieting behaviours, leading to obsessions with food and loss of social contact with others.

Alongside the growing prevalence of wellness trends, a number of newly formulated 'psychologically informed' diets have become popular, including WW (aforenamed Weight Watchers, who have also developed a children's diet app named Kurbo) and Noom (billed as an 'anti-diet'). In order to stay relevant and generate a new cohort of dieters, industries are attempting to appeal to the millennial tech- and psychology-savvy generation. These eating programs purport to include psychological techniques to support weight-loss,

including behavioural and cognitive methods to change individuals' eating patterns and overall health. For example, Noom uses a system of green (eat freely), yellow (moderate) and red (limited) foods to indicate what should or should not be eaten to lose the amount of weight entered by the user, and users are allocated a "behaviour change coach" to provide "positive reinforcement". The user is encouraged to enter food eaten into the app, and based on calorie content of food, the app tells users when they have reached their daily allocation.

Although app-based behavioural change and tracking of food could be experienced as beneficial and accessible for some, there are concerns around the lack of quality evidence-based strategies utilized in these programmes (Pagoto et al., 2013; Zhao et al., 2016). Further, Olson et al. (2021) argue that the impact of weight stigma is overlooked within the design of these apps. For example, users entering their food consumption and being given a 'grade' (e.g. C-) or receiving feedback that they are "slacking off" can exacerbate unhelpful associations around passing or failing with food and reinforce weight-related stereotypes of 'laziness' without thought to contextual factors affecting food choices. Although the branding for these products may have shifted, these diet programs continue to perpetuate the harms of dieting and a focus on weight loss, and may be more misleading to the consumer than traditional diets by using anti-diet language in how they promote themselves.

In sum, the pursuit of wellness and health can be co-opted by diet culture. The morality and stigmatisation of certain foods and the promotion of 'lifestyle diets' can lead to disordered eating, including Orthorexia. Reformulated 'non-diet' diets may be misleading for the public and particularly pernicious for those with histories of disordered eating. These restrictive behaviours and programs have become normalized in Western cultures and should be a cause of concern for health care practitioners.

Contextual effects on weight

The stress experienced by those in larger bodies has been shown to be associated with the impacts of weight stigma, which has adverse outcomes for both mental and physical health. Weight stigma can be defined as negative attitudes and beliefs toward others because of their weight, seen through stereotypes and/or prejudice towards those classified as overweight or obese (World Health Organization Europe, 2017). Weight discrimination is reported to have increased exponentially with Andreyeva et al. (2008) documenting a 66% increase in the United States through self-reported survey data in recent years. More women are reporting experiences of weight discrimination, concurrent with increases in public health campaigns to "tackle obesity" (Daníelsdóttir et al., 2010). Examples of weight stigma can include offensive language (e.g. "fat" being used as an insult rather than a neutral descriptor), being denied healthcare, not being recruited to a job, being unable to find clothing in your size or being excluded and ignored by others due to your weight.

Vadiveloo and Mattei (2017) found that over a ten year period, controlling for BMI and waist to hip ratios, those experiencing weight stigma had a twofold risk of developing a range of adverse physiological effects (or allostatic load). They postulate that the impact of weight stigma and the chronic stress experienced adversely affect physiology and ultimately mortality, independent of any physiological impacts of the individuals' higher weight. Experiencing weight stigma in and of itself is associated with a wide range of outcomes, including increases in mortality, type 2 diabetes, obesity, diabetes risk, metabolic syndrome, cortisol level (stress markers), high blood pressure, oxidative stress level, poor blood sugar regulation, C-reactive protein level (inflammation markers), depression, anxiety, body image dissatisfaction, low self-esteem, binge eating and eating disorders (Andreyeva et al., 2008; Annis et al., 2004; Bacon & Aphramor, 2011; Benas & Gibb, 2008; Mensinger et al., 2018; Puhl & Suh, 2015; Tomiyama et al., 2018; Wu & Berry, 2017). Social health can be significantly affected by weight stigma, which increases social isolation and social phobias, and negative experiences in relationships such as rejection, bullying and inequalities

(Ashmore et al., 2008; Wu & Berry, 2017). The evidence indicates that weight stigma is associated with poor health across a multitude of domains.

Further, those in larger bodies may avoid situations which increase their risk of experiencing stigma, such as exercising or eating in public and medical intervention, interfering with health promoting behaviours (Tomiyama et al., 2018). Weight stigma in healthcare settings is particularly problematic and pernicious. Stigmatising attitudes and beliefs of healthcare professionals affect their clinical judgement and provision of care toward patients (despite intentions to provide high-quality care) and lead to breakdowns in provider-patient relationships, mistrust, low treatment adherence, stress, and treatment avoidance for patients (Phelan et al., 2015). These ruptures in experiences of care can have significant and fatal impacts for those in larger bodies and are unfortunately pervasive (Mensinger et al., 2018; Phelan et al., 2015; Tomiyama et al., 2018). The overall consequences of weight stigma are so considerable that Tomiyama et al. (2018) identify it as a *significant unrecognized agent* for its negative impact on health.

Wider contextual factors can also have a significant impact on health status. The social determinants of health encompass socio-economic factors including housing, income, education, transportation availability and culture, which can equate to around 50% of an individual's health status (Braveman & Gottlieb, 2014; Hunger et al., 2020). For example, it is widely acknowledged that those in higher socio-economic brackets have better health outcomes overall compared to those living in deprived areas of the UK (Foster et al., 2018; Taylor et al., 2016). Research investigating the relationship between Socio Economic Status (SES) and lifestyle factors has found that lower SES households are more harmed by equivalent levels of smoking, high alcohol consumption and low physical activity than their higher SES counterparts (Katikireddi et al., 2017; Pampel & Rogers, 2004). The mechanisms underlying these findings are unclear but it is hypothesized that psychosocial stress (Nabi et al., 2013) and reduced access to healthcare (Mäkelä & Paljärvi, 2008), as mirrored in the weight stigma literature may contribute to the discrepancy. Further, the

history of weight stigma has important interconnections with race, sex and class systems of oppression which have many subtle and overt implications of discrimination and resultant health inequalities (Strings, 2019).

In sum, it can therefore be argued that a focus on individualization of obesity rather than on collective or population-level challenges can minimise the myriad, complex factors which affect individual weight gain or loss, such as the impacts of SES or weight stigma (Pearl & Lebowitz, 2014; Puhl & Heuer, 2009; Tomiyama, 2014). Further, there is evidence that the social determinants of health and the impacts of weight stigma independently contribute to poorer physical and mental health status. It is therefore important for population level social health policies and research to be tasked alongside public health and individual-focused interventions to tackle poor health outcomes.

The evidence behind Intuitive Eating

This section will describe the concept of Intuitive Eating and its core principles, the key mechanisms behind the IE approach and the efficacy of Intuitive Eating to date.

What is Intuitive Eating?

"Intuitive eating is a compassionate, self-care eating framework that treats all bodies with dignity and respect" (Tribole & Resch, 2020).

Disillusioned with the diet-influenced discourse around eating and body image, Intuitive Eating was developed by American dietitians Evelyn Tribole and Elyse Resch as a novel non-diet approach to supporting relationships to food, mind and body. Originally conceptualized in 1995, their framework now amalgamates the current research literature with their clinical expertise working with disordered eating. Tribole and Resch (2020) developed a guided self-help book laying out their Intuitive Eating framework, now in its fourth edition. The IE framework involves stripping back the rules and ideology connected to diets and diet culture, bolstering trust in self and developing a relaxed attitude toward food and movement.

Intuitive Eating has gained international attention as a health-promoting, holistic method to support individuals struggling with eating and body image, and continues to gain popularity (Tribole & Resch, 2020; Tylka, 2006). The literature in the field is expanding rapidly with over 125 studies to date showing promising improvements to both psychological and physical wellbeing for individuals who engage with IE. Intuitive Eating is becoming more common as an evidence-based intervention in general clinical practice, both in outpatient services and as an adjunct to inpatient eating disorder treatments (Thomas, 2019). At present in the UK, IE is primarily practiced within private settings as a treatment for those experiencing disordered eating. Although practitioners such as dietitians have anecdotally described using IE in their practice or are trialing IE groups in the NHS, there is no empirical data on the prevalence of this work to date.

Since 2007, Tribole and Resch have trained health professionals to Certification in Intuitive Eating to retain integrity and adherence to IE principles. Practitioners support clients to focus on internal rather than external cues, so therefore do not focus on weight loss, tracking calories, macros or points, or producing diet plans or giving advice on 'good' or 'bad' foods, all traditional diet tools. Rather, the framework covers ten key principles (Tribole & Resch, 2020):

1. Reject the Diet Mentality

The first step toward developing an intuitive relationship with food is to 'ditch the diets'. This starts with education and understanding of the harms that diets can cause both physically and psychologically. For example, recognizing the 'dieters' mentality' and psychological processes, including all or nothing thinking (being on or off diet), morality around food (good vs bad foods), and the processes of failure, obedience and willpower that are indicative of control around food. Finally, relinquishing use of dieting tools is encouraged, including weighing scales, fitness trackers and calorie counting so as to focus on internal, intuitive experiences with food and body. Active self-compassion is introduced and promoted

throughout the IE process in order to combat the internal criticisms associated with the dieting mentality.

2. Honor Your Hunger

This step supports people to tune into their biological hunger and to get into the habit of noticing their hunger and fullness cues. Checking in with this experience can decrease the likelihood of over- or unconscious eating patterns. Beginning to act on these hunger signals is the first step in developing trust with one's body.

3. Make Peace with Food

A focus on 'unconditional permission to eat' is developed. Deprivation or strict food rules can often lead to cycles of restriction and bingeing. This step focuses on unpicking morality around food choices and removing the guilt around food. Practical steps include making a list of foods that are appealing and eating them to see how this is experienced. Common food myths such as "I won't stop eating" are discussed and tested out.

4. Challenge the Food Police

This step involves challenging internal cognitions, including 'shoulds' and 'musts', 'good vs bad' foods and negative guilt-inducing internal critiques around food and body. Cognitive Behavioural Therapy (CBT) techniques are utilised to identify beliefs, thoughts, feelings and behaviour around food and strategies discussed for creating alternative, rational thoughts that combat common thinking traps. These techniques help to decrease internal 'food police, nutrition informant and diet rebel' voices, and increase 'food anthropologist, nurturer, rebel ally, nutrition ally and intuitive eater' voices.

5. Discover the Satisfaction Factor

This principle focuses on food as a vehicle for pleasure, satisfaction and contentment. Strategies include uncovering what clients really want to eat (noticing taste,

texture, aroma, appearance, temperature and volume of food) and the development of mindful eating in order to savour the food consumed.

6. Feel Your Fullness

Respecting and acknowledging fullness is the basis for this principle. Common barriers to this, such as rules around having to finish or leave food on your plate, distractions such as eating with others or watching TV, and difficulties in ascertaining fullness are discussed. Conscious-awareness eating, involving pausing mid- and post-meal or snack to reflect on experiences are encouraged in order to check in with fullness and satiety.

7. Cope with Your Emotions with Kindness

This principle explores causes and strategies to manage emotional eating. Although soothing through food may help in the short-term, managing boredom, anger, loneliness or anxiety through food does not address the root of the experiences. Meeting needs with kindness is discussed, including ideas for nurturing, managing and distracting from intense emotions, as appropriate.

8. Respect Your Body

Focusing on respecting one's body involves accepting it in the here-and-now and relinquishing control over the way it looks through accepting one's genetic blueprint. This principle discusses treating all bodies with dignity and respect and suggests some strategies to manage body comparison. Weight stigma, fatphobia and Heath at Every Size (HAES) are explored.

9. Movement – Feel the Difference

This principle encourages a focus on the experience and enjoyment of movement as opposed to calorie-burning or punishment through exercise. Common thinking traps and barriers to movement are explored such as not having enough time for movement.

Movement through everyday activities and finding movement that is fun are developed as key aspects of shifting an individual's relationship to exercise.

10. Honor Your Health with Gentle Nutrition

The final principle merges psychological and physical needs to honour taste and pleasure with health and long-term wellbeing. There is an emphasis on seeing the long-term picture, shifting from the need to eat 'perfectly' at every meal to an emphasis on the impact of eating patterns over time. Gentle nutrition is discussed including a focus on eating whole grains, fruits and vegetables, and ensuring sufficient protein and carbohydrates are consumed.

In sum, Intuitive Eating is an anti-diet framework for managing relationships to food and body. The approach is gaining increasing attention and utility across the world and research continues to indicate positive physical and psychological outcomes for those undertaking Intuitive Eating interventions. The framework covers ten principles to develop a healthy relationship toward food and body.

How is Intuitive Eating measured?

Two key studies were found to present empirical data on self-report screening instruments designed to identify the Intuitive Eating construct. Tylka (2006) developed a 21-item IE instrument, the Intuitive Eating Scale (IES), to measure the ability to follow internal satiety cues and physical hunger to decide when, what and how much to eat, with a test-retest reliability of .90. The three factor domains that represented IE principles (and IES subscales) were Unconditional Permission to Eat (r=.88), Eating for Physical Rather Than Emotional Reasons (r=.88) and Reliance on Hunger and Satiety Cues (r=.74). This study, using a non-clinical sample of 1,260 college-aged women in the United States, demonstrated adequate construct validity that offered initial support for the existence of the Intuitive Eating construct. Dockendorff et al. (2012) built on Tylka's preliminary work by evaluating the IES with 515 American middle school-aged female and male adolescents

(with a mean age of 12.5). Using concurrent validity, they found the IES scale and three factor domains to be valid for early adolescents and recommended some adaptations, including the addition of a factor for Trust in Internal Hunger/Satiety Cues. Both Tylka (2006) and Dockendorff et al. (2012) found that participants scoring higher on the IES indicated that they experienced less negative affect, internalization of the thin ideal and body dissatisfaction.

Tylka and Kroon Van Diest (2013) further developed and validated the IES with 2,600 adults, resulting in the 23-item Intuitive Eating Scale-2 (IES-2). The new scale has an internal consistency reliability of .93. The study, using a non-clinical sample of both men and women demonstrated adequate discriminant and convergent validity. This study also addressed a limitation of the original IES, by adding an additional factor of Body-Food Choice Congruence, associated with the Intuitive Eating principle of Gentle Nutrition. Total scores and most sub-scale scores in the sample were positively associated with body appreciation, self-esteem, psychological wellbeing and high interoceptive awareness, and inversely related to disordered eating, body shame and poor interoceptive awareness, amongst other factors (Linardon & Mitchell, 2017; Tylka & Kroon Van Diest, 2013). Hawks et al. (2004) have also developed their own Intuitive Eating Scale using a four-factor model to measure IE (intrinsic and extrinsic eating, anti-dieting and self-care). Although both measures are validated, the IES-2 appears to be preferred and widely used in IE research studies, perhaps due to refinements made over time to the scale and its reported ability to better assess IE (Bas et al., 2017).

In conclusion, though further validations might be needed, the IES-2 appears to reliably measure the Intuitive Eating construct. Higher IE scores were associated with more positive and fewer negative factors related to food and body (Linardon & Mitchell, 2017; Tylka & Kroon Van Diest, 2013). Both scales developed by Tylka and Kroon Van Diest (2013) correlate with the mechanisms of interoceptive awareness, the underlying mechanism of Intuitive Eating as described in the following section.

How does Intuitive Eating work?

The principles of IE have been developed and modified over time in response to clinical feedback and developing research findings. The framework has been conceptualised to support individuals with their eating through two key mechanisms (Tribole & Resch, 2020):

1. Through supporting the development of noticing and connecting to physical sensations in the body, otherwise known as interoceptive awareness, to satisfy physiological and emotional needs (Principles 2, 5, 6 and 9).

2. To reduce psychological and cognitive interferences (such as rules, beliefs and thoughts) with that process (Principles 1, 3, 4, 7, 8 and 10).

Interoceptive awareness, or sensing internal bodily sensations, is the foundation of Intuitive Eating. It includes an awareness of both the basic physiological sensations of the body as cues for action, such as bladder regulation or hunger and fullness, as well as the physical sensations of emotional experiences. These physical sensations give the brain important information to ensure that physical and mental wellbeing needs are met (Quadt et al., 2018). Developing value and trust in these bodily experiences is central to the IE process alongside a rejection of external rules or influences that contradict this connection to the body. Interoceptive awareness is therefore the building block for the intuitive eating process.

In order to use this awareness successfully, sensitivity and responsiveness are required (Tribole & Resch, 2020). *Interoceptive sensitivity* is the accuracy of perceiving and processing body sensations. Herbert et al. (2013) examined the role of sensitivity in IE, using a heartbeat perception task to measure interoceptive sensitivity. They found that intuitive eaters had significantly more accurate results than those scoring low on IE. Further *interoceptive responsiveness* is required in order to act on awareness and sensitivity to body sensations. Oswald et al. (2017) found higher interoceptive responsiveness and awareness

in intuitive eaters and that they acted as mediators for the relationship between body appreciation and intuitive eating.

In summary, the principles of promoting and removing obstacles to interoceptive awareness are the cornerstone of the IE method. Interoceptive sensitivity and responsiveness have been identified as additional mechanisms that support the process of awareness, accuracy and action based on internal bodily sensations developed during an IE intervention.

Does Intuitive Eating have an effect on psychological and physical health outcomes?

Research on the effectiveness of Intuitive Eating is expanding rapidly. Bruce and Ricciardelli (2016) conducted a systematic review of the IE literature involving adult women between 2006 and 2015 (24 studies met eligibility criteria). Eligible studies were those that included women aged 18 years and older, a measure of IE, and assessed a psychosocial correlate of IE. Studies were excluded if they sampled from women under the age of 18 years, sampled only from men, sampled from both men and women but findings were not analysed by gender, examined the effect of an IE intervention but did not include a measure of IE, or did not assess a psychosocial correlate of IE (Bruce & Ricciardelli, 2016). These data suggested Intuitive Eating was associated with *reduced* disordered eating, internalization of the thin-ideal, dieting and poor interoceptive awareness; and *higher* self-esteem, positive body image, emotional functioning, motivation to exercise, life satisfaction, psychological wellbeing and self-regard, amongst other correlates. They noted however that the research reviewed was cross-sectional and predominantly conducted with university-aged women in the United States, which limits conclusions which can be drawn about causality and generalisability.

More recent data draw attention to the longitudinal psychological and physical benefits of IE and with more diverse populations. Hazzard et al. (2020) drew data from a population-level, naturalistic study in the United States measuring self-reported eating

behaviours, physical activity, weight and other related factors, which included questions representing items from the Intuitive Eating Scale (IES). 1,491 participants met criteria to be included in the analysis, with a mean age of 14.5 years at baseline and 22 years at follow-up. The population was diverse with respect to sex, race and socioeconomic status. Greater IE levels at baseline and increases over the study period were associated with lower odds for risk of depression, low self-esteem, body dissatisfaction, weight-control behaviours and binge eating, the latter of which particularly strong associations were observed. Although these data are promising it is clear that further research in this area is required, particularly to ascertain the temporal effectiveness of IE treatment.

Research on the utility of Intuitive Eating for those experiencing eating disorders has gained attention in recent years. Particularly promising research has been conducted with individuals with binge-eating disorder. Studies of IE interventions have shown significant reductions in binge-eating following treatment, with some participants no longer meeting diagnostic criteria (Kristeller & Wolever, 2011; Smitham, 2008). Although the research in this area is still in its infancy, results so far are promising. IE interventions may also reduce disordered eating behaviours in non-clinical populations. Burnette and Mazzeo (2020) conducted a recent pilot study which found that both group and guided self-help IE interventions reduced disordered eating, weight-bias internalization and body dissatisfaction in a cohort of racially-diverse women attending university. In addition, an increase in Intuitive Eating, participant body appreciation and life satisfaction were indicated.

Intuitive eating has also been associated with indicators of physical health. A number of Randomised Control Trials (RCTs) have been conducted investigating the impacts of eating intuitively on a range of outcomes. For example, the study by Bacon et al. (2005) recruited obese female chronic dieters, measuring a Health at Every Size (HAES) intervention, a fundamental part of which included learning how to eat intuitively, against a weight-loss program. The HAES participants showed sustained improvements at two year follow-up in total cholesterol, LDL cholesterol, systolic blood pressure, higher levels of

physical activity and weight stability. A number of other RCTs have found a link between eating intuitively and maintained or lowered weight (e.g. Gagnon-Girouard et al., 2010; Hawley et al., 2008) whilst some have not found a significant association (e.g. Cole & Horacek, 2010). It is important to note that whilst changes in weight have been studied, weight loss is not a goal of interventions given Intuitive Eating's weight-neutral stance.

Cross-sectional and non-RCT clinical studies have found associations between IE and weight stability (e.g. Tylka et al., 2020). In addition improved blood glucose management for those with Type I (Wheeler et al., 2016) and Type II diabetes (Willig et al., 2014) has been indicated. Limited evidence of improved dietary intake has been found; the RCT by Hawley et al. (2008) indicated improvements measured via the Dietary Quality Score, and cross-sectional studies have found positive association with fruit and vegetable intake (Saunders et al., 2018) and time taken to eat at meal times (Madden et al., 2012), in line with gentle nutrition and mindfulness-based principles of IE.

There is currently sparse qualitative literature exploring experiences and perceived benefits of IE. Two studies have done so to date. Research by Barraclough et al. (2019) with 11 middle-aged women in New Zealand who had completed a web-based IE programme found that women were able to develop and benefit from IE skills but highlighted a number of challenges in doing so. In particular, social barriers and fears of weight gain were described as challenges to implementation of some aspects of their IE treatment, such as the principle 'unconditional permission to eat'. Research by Erhardt (2021) with eight UK-based participants who had been practicing IE for at least a year-and-a-half identified the importance and challenges of IE as a 'counter-cultural' process working against diet culture and the difficulties negotiating this in a social context. Participants employed strategies such as engaging with support from the online IE community to combat these challenges. Participants also spoke to an ongoing process of 'self-actualisation', developing trust in self and body and aligning with personal values as an important aspect of their Intuitive Eating experience. Further qualitative studies are required in order to understand how IE treatment

is experienced and to ensure that interventions are as effective as possible, driving the development of efficient IE treatment.

The literature thus far indicates a number of benefits for those engaging with Intuitive Eating. However, there are some shortcomings in the literature base that require attention. For example, although preliminary evidence with more diverse populations has indicated benefits further research on experiences and effectiveness is required; much research on Intuitive Eating to date has been conducted with cisgender white women predominantly in the United States and exclusively in Western countries (Bruce & Ricciardelli, 2016). As IE treatment is not a widely offered resource, it is important to understand how individuals across genders, sexualities and ethnicities, amongst other characteristics, experience IE treatment beyond the narrow sample who have been included in research thus far. The limited sample characteristics could be reflective of a number of issues including the accessibility and affordability of IE treatment, an important concern for wide-scale feasibility and integrity of interventions. To date, some studies have trialled group or guided self-help modalities of IE which have shown some preliminary success (Burnette & Mazzeo, 2020). Finally, there is an absence of studies exploring the qualitative experiences of those receiving Intuitive Eating interventions, which are important to add depth and nuance to our understanding of the experience and impact of IE interventions as well as their acceptability.

To summarise, the current research base for Intuitive Eating is showing both promising and more established benefits to psychological and physical health. Long-term benefits and experiences of more diverse populations are beginning to be evidenced, but further research is required to add to the breadth and depth of current findings.

An anti-diet approach to health: Health At Every Size (HAES)

Given the risks of dieting and related 'Weight-Centered Health Paradigms' (O'Hara & Taylor, 2018), health professionals, academics and anti-diet activists have developed alternative operationalisations of health promotion. For example, Lindo Bacon has pioneered

the Health at Every Size (HAES) movement which promotes a weight-inclusive stance on eating and body image. HAES is a trans-disciplinary approach focusing on health promoting *behaviours* rather than weight loss, and is closely aligned with but not limited to Intuitive Eating principles (Bacon & Aphramor, 2011). Where Intuitive Eating interventions focus on the ten principles as outlined by Tribole and Resch (2020), HAES is a paradigm within which HAES-aligned interventions such as IE sit. It therefore has a wider scope than IE, as described below. Its aims are to support individuals and systems to focus on behaviours that optimise adequate nutrition, movement and psychological wellbeing for those living in any sized body.

Health at Every Size principles include the following:

- Weight inclusivity: A neutral stance toward weight (neither vilifying or idealizing) is adopted. The range of body shapes and sizes of individual bodies is respected and accepted.
- Health enhancement: Systemic and individual policies are supported which promote accessibility to information and services and pay attention to individual needs (including physical, psychological, social, economic and spiritual).
- Respectful care: Social justice is an integral part of the HAES paradigm. Understanding and acknowledging internal biases and actively contributing toward ending weight discrimination, stigma and bias is part of the process. Practitioners work from an understanding that race, gender, age, sexual orientation, socio-economic status and other identities will intersect with experiences of weight stigma.
- Eating for well-being: A focus is given to eating intuitively and personally based on a combination of hunger, nutritional needs, satiety and pleasure. Flexible and individualized eating is promoted and internal rather than external focus is encouraged (including a lack of focus on weight).
- Life-enhancing movement: Activity is promoted that is inclusive of weight and ability and a focus on enjoyment through movement is encouraged.

HAES-focused interventions have been found to increase intuitive eating and quality of diet (Carbonneau et al., 2017), reduce disordered eating (Provencher et al., 2009), improve long-term psychological wellbeing (Gagnon-Girouard et al., 2010), improve physical health such as blood pressure and fitness levels and reduce the risk of type-2 diabetes and heart disease (Bacon et al., 2002; Bacon et al., 2005; Carroll et al., 2007; Gaesser et al., 2011; Messier et al., 2008). To date, no studies have found evidence of adverse health impacts from HAES interventions.

To sum up, HAES is a weight-inclusive approach to promoting health that is aligned with Intuitive Eating principles. HAES principles highlight the opportunities to enhance health outside of the negative psychological, physical and social consequences of weight-focused paradigms and interventions have evidenced some of the positive benefits experienced by individuals. Both HAES and IE are promising approaches to managing health without the need for dieting.

Conclusion

This conceptual introduction has outlined the Intuitive Eating program and the essential theory and research underpinning both dieting for weight loss and the anti-diet approach to wellness, a central component of the IE philosophy. In sum, although further research is required, IE interventions have shown promise as an alternative approach to managing health without the harms associated with dieting.

Some of the challenges for anti-diet approaches to contend with are whether they are found to be culturally acceptable at a population level, given the ubiquity of diet culture narratives. Absent or inadequate education around what health means and the nuances of body weight are not widely discussed in schools or media, contributing to the development of stigmatizing beliefs about weight (Hunger et al., 2020) and upholding dominant cultural attitudes. Further, descriptions of obesity as an “epidemic” and stereotypes of people in larger bodies as lazy, gluttonous, unintelligent, unmotivated or unwilling to ‘simply lose

weight' have wide-ranging effects, from bullying and decreased educational achievement for children (Neumark-Sztainer et al., 2011) to minimized employment opportunities, lower salaries and reduced promotion rates (Roehling, 1999).

The evidence base explored in this paper raises some important questions for psychologists and allied health professionals. At present, government guidelines for obesity for adults involves assessment of weight and precipitating factors, and treatment advice including lifestyle interventions such as weight-management programmes, behavioural interventions involving self-monitoring and relapse prevention, physical activity, dietary support, and pharmacological or surgical interventions, as required (National Institute for Health and Care Excellence [NICE], 2014). Consideration should be given to the responsibility of health workers to understand and promote alternative options to weight loss and dieting and support a focus on the health-promoting behaviours, such as physical activity, known to support long-term health (Gaesser & Angadi, 2021). For example, psychologists can be key members of obesity management services and a multitude of settings where traditional medical advice for clients could include weight loss. We have seen the lack of efficacy for this approach as well as the myriad potential harms to individuals which brings up ethical dilemmas around weight loss treatment or advice. Further, stigmatization of those in larger bodies in healthcare settings is particularly concerning given the consequences of healthcare avoidance, a direct and insidious harm (Mensinger et al., 2018; Phelan et al., 2015). Professionals find themselves in positions of power relative to their patients; as with other forms of stigma, such as against those of varying sexual orientations, gender identities or mental health diagnoses, arguably health professionals have a duty to address the treatment of those in larger bodies in our profession.

There can be significant barriers to tackling these practices. Majority views around weight can be perpetuated due to a lack of awareness and nuanced education on these topics in traditional health care trainings, with practitioners unaware of alternative paradigms of health promotion. Further, challenging widely-held views is a risk, with professional and

social desirability pressures on individuals to conform to the majority view (Griskevicius et al., 2006). Psychologists may feel that educating or advocating around weight-inclusive practices is 'outside of their remit', as weight management is traditionally located within physical health settings. In addition, those who do not conform to weight-centered views of health can become ostracized or punished for not 'toeing the line', which can lead to real negative professional and social outcomes for individuals (Janes & Olson, 2000). Consideration should be given therefore to a focus on education and culture change across all levels of organisations to begin to tackle the negative impacts of weight-centric methodologies in both medical and mental health settings.

Aims of the thesis

This conceptual introduction outlined the underpinning research and theory behind Intuitive Eating, including an exploration of the evidence and theory around dieting and anti-diet approaches to wellness. Although the research base on IE is growing, there is currently scant evidence as to the acceptability of IE interventions. The empirical paper builds on the limited qualitative research conducted to date, exploring individuals' experiences of an IE intervention during COVID-19. Data were approached inductively, or in other words, the data determined themes developed through the thematic analysis. However, it was hypothesised that participants may offer their experiences of dieting, weight fluctuations, diet culture or weight stigma in their interviews. The overarching aims of the thesis were to explore experiences of the principles of Intuitive Eating and the perceived facilitators and barriers to implementing IE during COVID-19.

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Part 2: Empirical Paper

"Switching on a lightbulb": A qualitative exploration of the experiences of an Intuitive Eating (IE) intervention during COVID-19

Abstract

Aims: There is a lack of qualitative research examining the experiences of learning to eat intuitively. This paper aims to present an in-depth exploration of the experiences of individuals undertaking an Intuitive Eating (IE) intervention during the COVID-19 pandemic, exploring the experiences of IE principles, facilitators and barriers to implementing IE and the impacts of COVID.

Methods: Interviews were conducted with 11 women who had undertaken an IE intervention, which they received at least partly during the pandemic. Semi-structured interviews were conducted and analysed using thematic analysis (Braun & Clarke, 2006).

Results: 13 themes and five overarching domains were identified from the data: the experience of Intuitive Eating intervention was described as *life-altering* and *a process of self-exploration*. Participants described their experiences of *finding liberation through lockdown* and *the challenges of COVID* and discussed the societal impacts on their IE experience (‘*not operating in a vacuum*’).

Conclusions: The study is the first to examine experiences of an IE intervention during a pandemic, providing novel insights. Findings suggest that overall the IE model was experienced favourably, with some respondents describing the principles as life-altering and challenging, such as developing unconditional permission to eat. It highlighted that the pandemic had both positive and negative impacts on IE, such as increased time to focus on treatment and fears of missing out on ‘in vivo’ learning due to the pandemic. Societal and social impacts were also discussed, including external pressures on body image and the role of support from others in treatment.

Introduction

There is significant debate as to the most effective and appropriate ways to support individuals with their health, particularly where weight-related concerns are expressed by individuals or professionals (Brownell & Rodin, 1994; Dulloo et al., 2015; Mann et al., 2007; Taylor. et al., 2015; Volek et al., 2005). Some researchers and clinicians are proponents of deliberate food restriction, or dieting, and there is evidence that weight loss can improve health outcomes across a variety of quality of life measures, including mobility and diabetes markers (e.g. Ryan & Yockey, 2017). However, there is also a considerable evidence base that indicates that dieting is often ineffective and can be harmful. Dieting has been found to negatively affect mood, self-esteem, body image, physical health, food preoccupation and disordered eating, and is a significant, pervasive risk in the development of eating disorders (Bacon & Aphramor, 2011; Canetti et al., 2002; Goldschmidt et al., 2016; Hilbert et al., 2014; Ward & Mann, 2000). Further, not only are diets ineffective for the vast majority in the long-term, they have also been found to be the most consistent predictor of weight gain over time (Mann et al., 2007; Neumark-Sztainer et al., 2006; NIH Technology Assessment Conference Panel, 1992; Rothblum, 2018). The process of weight-cycling, or gaining and losing weight in a cyclical fashion, is common amongst dieters and particularly concerning given its associations with serious physical health outcomes (Field et al., 2004; Montani et al., 2015; O'Hara & Taylor, 2018). The psychological burden of dieting should also not be ignored; research has indicated that even anticipatory food restriction can lead to bingeing (Urbszat et al., 2002), and that the internal attribution of repeated failure to lose weight or maintain weight loss may mechanistically cause the low self-esteem and depression experienced by many dieters (Heatherton & Polivy, 1992). Questions have therefore arisen as to the utility and ethics of continuing to prescribe dieting and weight-loss to the general public as a means to increase health and whether there is a viable alternative to dieting.

Intuitive Eating (IE) was developed as a response to these challenges, as a weight-inclusive, anti-diet alternative to support individuals with their eating and body image (Tribole

& Resch, 2020; Tylka, 2006). The IE framework involves stripping back the rules and ideology connected to diet culture, including recognizing the dieters' mentality, relinquishing use of diet tools (e.g. calorie counting, food trackers) and developing self-compassion; bolstering trust in self to decide what and how much to eat rather than using external rules; and developing a relaxed attitude toward food and movement. Importantly, IE helps individuals to develop a greater sense of their internal cues, or interoceptive awareness, which includes an awareness of both the basic physiological sensations of the body as cues for action, such as hunger and fullness, as well as the physical sensations of our emotional experiences in order to negotiate what and how much to eat (Oswald et al., 2017; Tribole & Resch, 2020). IE operates outside so-called Weight-Centered Health Paradigms, which assume health is directly correlated to weight (O'Hara & Taylor, 2018) and is aligned with movements such as Health at Every Size (HAES), (Bacon et al., 2002) which understand that health can be promoted for individuals regardless of their weight. IE aims to promote health and wellbeing without a focus on weight, and operates with acknowledgement of wider systemic and societal impacts on health status.

IE has grown in popularity and continues to gain attention, with research on its effectiveness and acceptability increasing significantly in recent years (Hazzard et al., 2021; Schaefer & Magnuson, 2014; Tylka, 2006). Bruce and Ricciardelli (2016) conducted a systematic review on studies involving adult women between 2006 to 2015, finding relationships between Intuitive Eating and *reduced* disordered eating, less internalization of the thin-ideal, dieting and poor interoceptive awareness; and *higher* self-esteem, positive body image, emotional functioning, motivation to exercise, life satisfaction, psychological wellbeing and self-regard, amongst other correlates. In addition, improvements in physical health indicators have been associated with IE, including metabolic fitness (Bacon et al., 2005; Van Dyke & Drinkwater, 2014) and blood sugar control (Wheeler et al., 2016; Willig et al., 2014). Although promising, much of the data to date have been from cross-sectional studies; longitudinal data, such as a recent cohort study by Hazzard et al. (2021) are now

beginning to evidence a number of these outcomes including lower odds of depression, poor self-esteem and binge-eating.

Whilst there are a number of quantitative studies of the effectiveness of IE, there is a significant lack of qualitative research investigating the experiences of IE interventions. It is important to collect this data in order to understand how IE treatment is experienced and to ensure that interventions are as effective as possible, driving the development of efficient IE treatment. In addition, gaining an understanding of clients' experiences of the benefits and challenges of engaging with and implementing IE can ensure adequate support is considered. Two qualitative studies to date have begun to do so. Research by Barraclough et al. (2019) with 11 middle-aged women in New Zealand who had completed a web-based IE programme found that women were able to develop IE skills but experienced a number of challenges in doing so. Social barriers were described as affecting their ability to implement IE, such as feeling an obligation to eat at social events and not wanting to be perceived as 'rude' or 'weird' for eating intuitively (Barraclough et al., 2019). Further, participants experienced the IE principle of 'unconditional permission to eat' as the most challenging to embrace, in part due to fears of gaining weight as a result. Interestingly, some participants used weight loss as a measure to evaluate their success at IE, despite its intrinsic weight-inclusive stance. More recently, research by Erhardt (2021) with eight UK-based participants who had been practicing IE for at least a year-and-a-half identified themes of IE as a 'counter-cultural' process working against diet culture and the challenges of negotiating this in a social context. Participants described strategies of 'self-protection' in order to combat these difficulties, such as engaging with the online IE community. Finally, participants spoke to an ongoing process of wider 'self-actualisation', developing trust in self and body and aligning with personal values through IE work.

Interestingly, both studies highlight the significant impact of contextual and societal factors on participants' experiences of IE. In the present study participants' experiences are explored in the context of the novel global pandemic, COVID-19. Emerging evidence is

indicating that the pandemic has affected mental health at a population level (Nutley et al., 2021; Phillipou et al., 2020). Health professionals have been particularly concerned about the interactions between COVID and eating behaviours. For those with historic or current eating disorders, re-emergence or worsening of symptoms have been linked to outcomes of the pandemic such as increased isolation, food scarcity and significant disruption to daily living (Branley-Bell & Talbot, 2020; Clark Bryan et al., 2020; Termorshuizen et al., 2020). Population-level studies have indicated that even for those without a history of eating disorders, increases in food restriction and binge eating were reported, hypothesized to be linked to increases in stress, anxiety, depression and food scarcity during the pandemic (Phillipou et al., 2020).

No research to date has explored the experiences of applying an IE intervention during a period of restricted movement and food availability, such as the pandemic. This study aims to add to the current evidence base indicating which areas of IE are found to be most helpful as well as highlighting which areas may be more challenging to maintain, specifically during a novel world-wide pandemic. This could indicate which areas of IE may be easier or more difficult to maintain during other periods of crisis, anxiety or stress in individual's lives. This qualitative study aimed to explore the experiences of participants undertaking an IE intervention during COVID-19; specifically, experiences of the principles of IE and the perceived facilitators and barriers to implementing IE during COVID.

Method

Participants

All participants were recruited from the London Centre for Intuitive Eating (LCIE), a private team of Nutrition Counsellors based in London, UK. Recruitment criteria were that participants had received an Intuitive Eating intervention (a minimum of four sessions post-assessment) which overlapped with the COVID-19 pandemic in the UK (i.e. at least some

sessions occurring after March 2020), were over 18 years of age and were not experiencing an active clinical eating disorder (as screened by clinicians at the LCIE).

Eleven participants were recruited to the study. Participants ranged in age from 23 to 42 years (*M*=32.3 years, standard deviation (*SD*)=6.3 years). All participants identified as ethnically White and presented as Female. Twenty-five participants were approached by LCIE clinicians for the study, with around 35 active clients at the time of recruitment who were at different stages of treatment. All participants who opted to take part in the study were interviewed.

Participants' difficulties with food prior to IE treatment were varied, with some experiencing clinical eating disorders. All participants described experiences of diet cycling or food restriction and a challenging relationship to food and their bodies prior to beginning IE treatment. Participants' expectations of benefits from treatment, broadly speaking, were to develop a healthier, less stressful relationship to food and their bodies and to learn to eat intuitively. Client session fees ranged between £75 and £100 depending on clinician experience.

Procedure

Potential participants were initially contacted by a clinician from the LCIE to take part in the research and were sent an information sheet (Appendix A) and consent form (Appendix B). If they were interested in possible participation, the researcher met with them online and gained consent before interviewing them via Microsoft Teams or phone for up to one hour. Interviews were recorded via Microsoft Teams and UCL-approved data security guidelines were followed.

A semi-structured interview guide was utilized for interviews (Appendix C). The areas that were focused upon included:

1. Participant experiences of Intuitive Eating principles and their intervention generally, i.e. what they liked and found helpful and disliked/found unhelpful;

2. Perceived facilitators and barriers to their Intuitive Eating intervention due to COVID.

Topic areas were selected to elicit participants' thoughts on the experiences of their Intuitive Eating intervention and how their experience of COVID interacted with that process. The design of the semi-structured interview protocol drew on the limited qualitative research in the field to date, as noted, and generation of questions related to experiences of their IE intervention drew upon the work of Barraclough et al. (2019) who aimed to explore the motivation and perceptions of participants' experiences of eating intuitively as well as the facilitators and barriers to doing so. The researcher attempted to establish rapport with participants and to conduct the interviews in a conversational style. Questions were tailored to participants' circumstances, for example whether they commenced their intervention pre- or peri-pandemic.

Analysis

Thematic analysis was selected as an appropriate methodology for the present study given its simultaneous rigour and flexible theoretical approach (Howitt, 2019). Further, it is possible to derive descriptive and interpretative data to make sense of the phenomena studied, from the participants' perspective, central to the exploratory aims and novel nature of the present study (Braun & Clarke, 2006).The phases of thematic analysis were guided by Braun and Clarke (2006) whereby the analysis was data driven in line with the exploratory and descriptive purposes of the research. The method of thematic analysis enables researchers to systematically identify, synthesise and interpret patterns of meaning across rich and complex datasets (Braun & Clarke, 2006).

Interviews were transcribed verbatim with the support of two University College London (UCL) undergraduate students who were trained to transcribe to an appropriate level of detail. All transcriptions were then checked by the researcher against the original audio files for accuracy and corrected where necessary.

Each transcript was read multiple times to aid immersion and familiarization with the data, with initial thoughts noted during the process. An inductive or 'bottom-up' approach was followed to develop themes from the data. Transcripts were systematically coded into units of meaning (phrases or sentences) generating initial codes across the data set. Coding style was influenced by Saldaña (2013), and the two coding styles most frequently used were 'descriptive' and 'in vivo' coding in order to remain close to the data set (see Appendix D for an example of an analysed transcript). Two independent researchers coded two transcripts each as a credibility check on the data (Barker & Pistrang, 2005), revealing a high level of inter-rater agreement when compared with codes generated by the researcher.

The third stage of coding saw initial codes collated into potential themes, whereby codes with similar content were grouped under more abstract codes. A frequency tally was kept in order to monitor breadth (how many participants mentioned similar codes) and depth (how many times any single participant mentioned the same codes). An extract of this stage of analysis is provided in Appendix E.

These candidate themes were then reviewed during the fourth stage of analysis to ensure that they matched both individual codes and the full data set. The original 16 candidate subthemes were reviewed and re-worked against the coded data, using colour coding to support the reviewer to create 'theme piles' of how the codes and themes worked together, refined down to 13 subthemes clustered under five overarching themes. Further, the individual themes generated were considered against the wider data set and refined where appropriate (an extract of this stage is provided in Appendix F). One of the independent researchers involved with coding transcripts in the initial stages of analysis reviewed the researcher's map of codes and themes to check for face validity of concepts. Finally, themes were refined, defined and named in consideration of the overall analysis and research aims (see Table 1). Vivid extracts to represent themes were selected whilst refinement remained ongoing throughout the final stage of report writing.

Reflexivity

Throughout the process of conducting this research, I have been aware of the importance of reflecting upon and acknowledging my personal stance on Intuitive Eating and how this might influence the research process. Given my own use of and enthusiasm about IE, the topic was of personal interest. Whilst attempting to maintain an 'authentic openness' to the topic, interviews and subsequent analysis, pre-existing prejudices undoubtedly influenced this experience in my attempts to understand the data and tone with which it was presented (McMyler, 2000). Prior to interviewing I undertook a bracketing interview with one of my trainee colleagues, a tool that can support the researcher to become aware of what they are bringing to the research, including their life experiences, cultural factors and expectations from the research (Fischer, 2009). This process supported my reflexivity on the topic. For example, given my interest in IE and in evidencing its utility, I increased my awareness of the opportunity and time I was facilitating in interviews for participants to share their less positive experiences of IE.

Although I attempted to put aside and bracket my views on the topic, it is important to acknowledge that it is not possible to attain 'detachment' to the research and that material was co-constructed between myself as researcher and participants. Given my 'insider' status in the research as someone who has also utilised IE principles, it was therefore even more important to attempt to adhere to a reflexive, inductive stance to interviewing to focus on participants' unique experiences rather than assuming meaning based on my own experiences (Hayfield and Huxley, 2015). As discussed on reflection input such as member checks on the interview protocol and study data could have been utilised to support credibility and confirmability of the data (Nowell et al., 2017).

Ethics

The study was approved by the UCL Research Ethics Committee (Research Ethics Committee reference number 18501.001, Appendix G).

Results

Participants who underwent an Intuitive Eating intervention during COVID-19 provided many examples of their experiences of IE treatment and the facilitators and barriers to treatment impacted by COVID. Five key domains were identified, namely Intuitive Eating is life-altering, a process of self-exploration, finding liberation through lockdown, the challenges of COVID and 'not operating in a vacuum'. These domains were subdivided into 13 central themes (see Table 1). Verbatim extracts from interviews are included to ground the themes identified in participants' words and to add depth to the readers' experience of the data. Sections of transcript where text has been omitted are identified by ellipses (…). Where IE principles are introduced throughout the text, they are italicized and punctuated.

Table 1. Domains and Themes

Domains	Theme
Intuitive Eating principles are life-altering	You can't 'unsee' diet culture
	Giving yourself permission is radical
	Intuitive Eating is hard work
A process of self-exploration	Letting go of external rules
	More under the surface
	Brain and body beginning to trust each other
Finding liberation through lockdown	Protected from external factors
	Time and space to focus on self
The challenges of COVID	Fear of losing control
	Missing out on learning
'Not operating in a vacuum'	Pressures on body image
	Support from others
	The social media community

Intuitive Eating principles are life-altering

Across interviews, participants expressed the life-altering impact of Intuitive Eating principles:

> "It's like a perspective change, almost like you're converted, isn't it? The way you interact with the world as a whole has completely shifted, for me anyway" (P2).

All participants gave voice to the value of '*Rejecting the diet mentality*', feeling that once informed, **you can't 'unsee' diet culture:**

> "It's that feeling of, like, someone opened my eyes or switched on a light bulb and once you see it, once you notice how pervasive diet culture is, you can't go back. There is no unseeing it" (P1).

The experience of working through this principle brought up strong emotions, including anger:

> "The rules that I've been subjected to about what a woman should look like…It's robbed me of a lot of experiences in my life! And relationships! You know? Like avoiding seeing people at times, cause I just felt so down about my appearance" (P5)

and relief:

> "It's nice to have that validation I guess, that it wasn't me, it wasn't my lack of willpower…It's just science, it was my body trying to protect itself. So, it's quite nice to have that sort of vindication" (P1).

A process of 'shifting the blame' for dieting failures from the self to diet culture appeared to be a central factor in participants' positive experiences and motivation to reject dieting.

Whilst many participants were exposed to rejecting diet culture prior to IE treatment through social media, podcasts or books, other concepts took longer to adjust to. The

principle '*Making peace with food'* and in particular developing 'unconditional permission to eat' meant that for participants, **giving yourself permission is radical**:

> "I think because it was the most contrasting to my life thus far, after years being told the opposite. It felt really radical to be honest…Unconditional permission to eat has been the most life-changing and also the hardest to really start to implement in my life because it was just such a leap from those kind of thought patterns that I had in the past around food" (P6).

Most participants experienced the swing from control to permission around food initially intimidating, with fear of weight gain a significant source of concern:

> "I think in general, the whole concept of the unconditional permission took a long time to get used to because there's this worry that if I let myself eat whatever I want whenever I want, what if I just go mad on like this gigantic binge for the rest of my life? But obviously that doesn't actually happen…you have to let go of the worry that you might put on weight because you're eating whatever you want instead of controlling everything" (P3).

For some participants, this fear led to an ongoing 'back and forth' with trust in unconditional permission, which Tribole and Resch (2020) describe as the 'guilt versus deprivation seesaw'. The majority of participants however described slowly gaining equilibrium with the principle:

> "I was always in 'diet land' or 'doughnut land', it was always one extreme or the other, whereas now I feel more like in the middle…I'm not as panicked about it, I'm more like, 'Okay, this is the process'" (P10).

A common through line as participants spoke about their treatment was that **Intuitive Eating is hard work**. Many spoke to a lack of clear rules or plan to follow as challenging:

> “The times I find it hard are when I wanted that quick fix, external guidance of like here's a list (laugh) you know, and [IE practitioner] wouldn't do that for me” (P6).

A number of participants internally attributed this frustration as inherent to themselves as opposed to a common IE process:

> “I think this is me rather than Intuitive Eating, but I really want some rules for what's OK to eat and what's not OK to eat, and I understand that this is all about putting foods on a level, eating the ones that feel good, but it still feels really stressful to me sometimes that there sort of isn't a plan. Like sometimes that's just really hard” (P4).

Others echoed the sentiment that it was due to their perfectionism, being “a list kind of person” or simply “a personality thing”. The crux of this struggle appeared to be in developing trust in internal rather than external permission:

> “I just want a bit of validation that I'm doing it right” (P4).

These experiences of internal doubt led to some participants contemplating a return to dieting:

> “I like to be really good at things. I don’t like being bad at things. So, I think to feel like I’ve gone backwards was a bit of a knock. It almost led to a bit of ‘this is too hard, dieting is easy, maybe I should give this up and go back to dieting?’” (P1),

particularly amidst moments of mistrust in the IE process:

> “It still feels a bit like, what if it's just another trend? What if it's just another diet? Even though I know it's not (laugh), I know what it is, you know. What if I'm just going to have to go on a diet again in a year?” (P5).

Although all participants reported struggling with IE, many were able to recognise this as part of a normal, albeit challenging, experience:

> "It feels like it's still kind of an ongoing process really. It's not like you can just switch all those voices off…you're kind of more informed and able to ignore them, those thoughts about food, just go, 'Oh that's just diet culture speaking to me again, I can bat that off'" (P2).

A process of self-exploration

A process of self-discovery and exploration featured heavily in participants' accounts of their Intuitive Eating treatment:

> "I just feel like I'm learning about myself, I'm getting to know a bit of myself that I haven't known until now. Cheesy, but yeah" (P1).

IE principles were created to improve and remove obstacles to knowledge of oneself, and specifically to 'Interoceptive Awareness', or the building blocks to understanding our physical and emotional needs (Tribole & Resch, 2020). A process of **letting go of external rules** was a key part of the unlearning participants described, finding IE principles a favourable alternative framework to think about food and body. Many shared their experience of the magnitude of this task:

> "A ton of the stuff that I was struggling with was listening way more to external things that were telling me what to eat and when to eat it and how much to eat, rather than being able to tune into anything that my body was telling me…so much of the Intuitive Eating messaging is about listening to your body, but when you have very aggressively not listened to your body, it's very difficult to know where to start with that" (P8).

As participants moved away from their prior 'agonising' over what to eat and released the rules or morality around food, they described their relationship with food and body as less stressful and experiencing more 'brain space' for other areas of their lives. Participants also

spoke of developing more kindness toward themselves whilst developing an 'internal mechanism' for making decisions about food with the support of their IE practitioners:

> "There's a lot of things to consider when you're thinking about food, but it no longer feels like you're walking this tightrope. And if you make a wrong step, plummet to your death (laugh), you know?" (P6).

Building up internal mechanisms and knowledge involved discovering that there is **more under the surface** than participants first thought:

> "There's some stuff that you do or work through, that maybe it's difficult because you maybe feel like there's a block there, or you've never thought about it before. And it felt like a lot of it was really challenging beliefs that you've held for so long…You realize it's actually linked to so many other things that actually there's so much more to it than what you see on the surface" (P3).

Participants spoke about the many 'layers' to their often 'subconscious' food rules and a process of

> "recognizing that what you feel is maybe not quite what it seems" (P11).

Specific examples of this were shared, such as one participant who felt that she uncovered the depth of her self-imposed 'mental deprivation' around food:

> "I might be eating all this food, but the entire time I was telling myself I shouldn't be. And I was just carrying all this guilt and shame, embarrassment, eating in secret, hiding food…I was able to just recognize it much more and you know, step away from all that talk, all that real derogatory, undermining stuff…that's been huge for me" (P5).

As participants released external rules and developed internal knowledge, interoceptive awareness was strengthened, with participants describing their **brain and body beginning to trust each other**. Many felt this was a 'turning point' in treatment:

> "I've spent so long being told that I can't trust my body, like my brain can't trust my body to tell it when it's hungry and my body can't trust my brain to feed it when it's hungry…I put so much time and money and effort, believing that I can't trust myself around food. I'm really enjoying learning that I can, and that those signals…I can listen to them. It's not all gonna go horribly wrong" (P1).

A few participants described a key part of this process as challenging specific fears around food, such as allowing previously 'off limits' food at home:

> "I always just assumed that given unfettered access to something like that, I would do nothing but eat it and I'd go crazy. So, it's just really nice and refreshing I guess, to know that's not gonna happen" (P1).

Participants conveyed their experience of feeling more 'in tune' with their bodies through principles such as '*Honouring hunger'* and '*Discovering the satisfaction factor'*.

Simultaneously, participants spoke to the emotional disconnection between brain and body around gaining weight:

> "With my brain I'm entirely down with the idea that weight and health are not necessarily related in the way that kind of diet culture has tried to convince us that they are and that you can be healthy at any size…logically I'm totally there. But emotionally that still feels really hard" (P4).

Similar sentiments were shared by nearly all participants:

> "I put on weight…I don't feel comfortable at the size I am. I don't like it. I'm not very accepting of it. So that clash with that, that is a big thing for me. And so I can get it, I'd say it's 'head knowledge' but not 'heart knowledge'"(P7).

For many participants, healing the emotional disconnect and working on body image became a central component of their IE treatment:

> "Repairing the relationship…growing my confidence back as part of it" (P3).

Finding liberation through lockdown

Alongside processing the life-altering and self-exploratory experiences of IE treatment, participants had to contend with the worldwide pandemic, COVID-19. As globally distressing as the context was, for participants undergoing IE treatment, there were many aspects of the lockdown experience they felt 'grateful' toward:

> "I found that aspect of lockdown was a bit of a gift to me actually. Because I found that being home more…I just found it kind of liberating" (P5).

Part of the liberation that participants described was attributed to feeling **protected from external factors** during COVID. Stay-at-home orders and home working were experienced to varying degrees by all participants, leading for some to a feeling of being

> "protected in a little bubble…without any of that stuff kind of challenging it. And then when you come out the other side of it, it's easier to feel a bit more protected from it mentally" (P2).

One of the challenges that COVID restrictions protected participants from was situations that sparked body comparison:

> "That influence, that sort of external force on your thinking about your body, makes it harder to achieve the body neutrality. And I don't think I would say I'm there yet, but it's probably easier when there's not that many people around and you're not sort of in person comparing yourself all the time" (P11).

Many spoke about the benefits of not having to contend with social events such as Christmas or public diet conversations:

> "At work I can hear everybody who chats in the kitchen…I do find it quite difficult sometimes, cause people are talking about ridiculous things about how fat they are when they're like teeny weeny, or talking about what they're not eating at the

moment…diet conversations are much easier for me to avoid now and that makes life much easier" (P4).

Participants found this experience of protection extended to having **time and space to focus on themselves**:

> "The pandemic for me has been a bit of a blessing. It's really made me sit and come to terms with a lot of things about myself and about things I've been through and have a bit of a health check" (P9).

Undergoing IE treatment during COVID helped keep participants'

> "mental health at a good level...and intact" (P3),

involving a focus on 'building tools for resilience' for many:

> "In the past my ability to self-soothe or respond to negative situations and stress and loneliness or whatever was very limited and often involved food… I've been able to see how these different things are serving me and continue to build on it rather than the pressure or stress of COVID pushing me backwards" (P6).

Due to COVID, participants felt able to slow down the treatment process and

> "listen to my own intuition more" (P9).

With more time and space, all participants described engaging with the process of

> "rediscovering the joy of food" (P3).

Buying cook books, making new recipes and having the time to prepare and enjoy food were commonly discussed:

> "Food has become one of the main pleasurable things that we can do when you're stuck at home all the time. And thanks to Intuitive Eating, I can see that as a good thing. I can enjoy that. Whereas before I think that would have come with a lot of guilt" (P2).

It is important to bear in mind that participant experiences of these 'benefits' of the pandemic were alongside receiving psychological support through their IE treatment and that those without this support might have had a very different experience. Participants expressed their concern for what the experience of COVID may have been like without treatment:

> "This would've been a nightmare if I was putting pressure on myself not to eat…you could go up and get whatever you want from your kitchen throughout the work day, and I think if I'd been calorie counting or dieting I'd think that was really hard, being in that position" (P10).

The challenges of COVID

Alongside the perceived 'silver linings' of COVID on participants IE treatment the pandemic presented significant challenges. Isolation, mental health difficulties, lack of structure and loss of activities were reported as significant factors contributing to a **fear of losing control**:

> "I live alone. So it's been a very, very isolating experience…And suddenly my relationship with food has gotten, I feel even more out of control than I usually do…So suddenly I'm having to make more food choices with no one else's opinion about it, with a ton of anxiety and no movement. Like it all kind of felt quite overwhelming" (P8).

A number of participants described this sense of overwhelm or 'over-processing' during COVID:

> "So the fact you're at home…You're just generally processing things on a more, like intense way. You're picking things apart a bit more…Having so much time could impact the way you see your progression. You could think you could be doing more things, you could be doing better, because you've got more time on your hands" (P9).

Participants described the difficulty 'switching off', whether rumination on their compliance with IE principles or their challenging relationship with food:

> "It's been quite hard being so aware of it all the time, like not being able to switch off from it…you're realising how much of an impact it's had on your life" (P10).

A sense of a lack of escape from both COVID and food difficulties became a prominent theme throughout interviews. For some participants, however, their fear of losing control was located in the future, post-lockdowns, where escaping from COVID may bring different challenges:

> "The draw of diet culture could sort of take hold again. Not necessarily successfully but I guess that's the downside of it is that it might make me feel like I'm being pulled back. Yeah, I expect it to get a bit harder when life goes back to normal" (P1).

Part of participants' concern for the future involved a sense of **missing out on learning** due to COVID:

> "I guess that not being able to take what I've learned…and apply it in practice to a situation like Christmas that would normally be so steeped in diet culture for me, I guess that would be a downside" (P1).

Nearly all participants spoke to this inability to 'test out' their learning in situations that were previously challenging such as social or work environments:

> "In our workplace there's constantly food around…All those things that I always deprived myself of. And then I would end up having these secret binges in the office. And now I'd be interested to go back into the office and see actually how I responded to all of that food and if that feeling goes away" (P3).

One of the most challenging IE principles for participants to test out during COVID was '*Movement – Feel the difference'*. Frustrations were expressed with not being able to

engage in their usual 'joyful movement' practices, or the barriers of learning what movement they enjoy due to restrictions:

> "I mean personally I found the exercise quite hard like the movement piece because the gyms have been shut and a lot of stuff that I would normally do has been shut…So exploring intuitive movement, it becomes a much smaller universe than it was before" (P11).

The barriers to movement appeared to exacerbate participants' struggles with body image:

> "I try to come at it from a place of non-judgement or a place of like, 'You've survived a global pandemic, you've done all this stuff…with the pandemic lots of people have put on weight you're just part of that', but still I feel like other people have put on weight and still have like a slim body and I've put on weight and I was already in a larger body…and I'm in an even larger body" (P10).

These internal struggles exacerbated by COVID were the motivation for some participants to seek support:

> "So on the one hand…It heightened a bunch of stuff that was already there. But on the other hand, it motivated me to reach out to LCIE, and I'm not sure when or if I would have otherwise. And I'm really grateful that I have. So it's bad and good. Like it is both worse than it would have been otherwise, and better than what it would have been otherwise" (P8).

Not operating in a vacuum

The importance of acknowledging societal and social impacts on experiences of food and body were expressed by participants throughout interviews:

> “Intuitive Eating has finally been that approach that is aware that we're not operating in a vacuum, you know?” (P6).

Participants described how external **pressures on body image** impacted them:

> “It's fine to have all of those ideas and theories if you're thin. (laugh) If you're not, and you're expressing those views, I think even I am second guessing myself…there are certain places and people where I just wouldn't go there…The commentary that the people around, feel they have permission to make remarks on your body, your size, the way you've changed…I realise is a construct of patriarchal, it’s very non-feminist, non-inclusive structures” (P5).

Many participants described how the IE approach acknowledged and supported them through navigating these external realities:

> “I could discuss those things with [LCIE practitioner], and sort of say ‘this is what I'm thinking, is this what's happening?’ and she’d be like ‘yes, it is and we don't need to play into these things. We can challenge them’” (P3).

Complementary approaches such as the Health at Every Size (HAES) movement (Bacon et al., 2002) were brought up by participants as important adjuncts to their IE treatment to support with self-acceptance,

> “especially as a person who tends towards being in a larger body” (P2).

Participants experienced varying levels of **support from others**, but the importance of encouragement from family, friends, IE practitioners and the wider IE community was referenced throughout interviews:

> “I think it felt like the kind of thing that I definitely couldn't do myself…’It’s all very well and good for these people that are coming along to their clinics…but for me sitting in my garden, reading this book, like there’s no way I can do any of this’” (P1).

Participants described the integral role that their IE practitioners played as a source of encouragement, as someone

> "who really understands" (P9)

and the relief of an external person providing permission:

> "I think if I hadn't had the sessions with [IE practitioner] I would probably have ended up giving up and just saying, actually, you know, it's not meant for me" (P11).

Through this support, some described offering help to others:

> "I've literally been sending the principles and telling everyone to get a book about Intuitive Eating…quite a few of my friends have even said to me…'That conversation we had when I was first gaining weight was really helpful and I often think back to that conversation' and literally all I'm doing is just repeating stuff that the nutritionist said to me…I felt like I had a set of tools available to me that a lot of my friends didn't have" (P6).

Other participants spoke to the challenges of sharing with those around them:

> "Other people, I think like who I'm closer to who know about it, I don't think they fully understand the concept, I think they see it as some sort of diet…whether or not they're not interested in it, or the diet mindset of restricting what you eat is just so ingrained in them that they're not ready to hear it or they don't want to hear it" (P10).

For those with less support, their IE journey was described as more challenging:

> "One of the things I struggle with is feeling kind of alone with it. You know, it's very hard. It's mostly what I use social media for…I don't really have anyone in my life at the moment who would be fully where I'm at…In the same mindset, so I can't really indulge in a free conversation with people in my life about this, at the moment. So it can feel a bit isolating" (P5).

A theme expressed by participants, particularly for those identifying as more isolated on their Intuitive Eating journey, was the use of **the social media community** including podcasts as tools of support or 'reinforcers':

> "Things like social media and being able to follow different people is really the best form for me of support because you see these people talking about the things that you've learned or you're thinking about and it inspires you. That you're doing the right thing, you're not like on your own in this battling against what everyone else is trying to sell…It's a good way of building a different type of community to what I had before on social media" (P3).

For other participants, however, social media could be experienced as more isolating when "exposed" to the plethora of diet culture-influenced opinions, or feeling an outsider to the online IE community:

> "Some of the broader conversation around Intuitive Eating makes me feel a little bit alienated because I am a woman who has been fat since puberty, and who has never been any good at dieting or aggressively exercising or being skinny. I am coming at this from a really different place than a lot of the people who are talking about Intuitive Eating on Instagram" (P8).

Although most participants described the IE social media space as supportive, experiences of alienation within the IE narrative (both on- and offline) bring up some questions around the overall accessibility and acceptability of IE for those with varied backgrounds, food histories and body sizes.

Towards the end of interviews, participants had the opportunity to express further comments about Intuitive Eating that hadn't yet been raised. Many used this moment to reflect on the wider societal impacts of IE:

> "I'm hopeful that this is the beginning of a change in society. I certainly hope it's a change for the women in our society" (P5).

Thoughts on the need for more support from societal institutions concluded one of the interviews:

> "I think I'd just say like for me, obviously I'm paying privately for the treatments that I've had…you can read books and things, but if it could be more accessible to people, or if there was something at school that you could do…From such a young age people are drilled to this diet mentality. It scares me a bit. Being out of it, looking into it…Like the way I like, live my life and the freedom I feel, is so liberating. I think everyone should kind of be entitled to have that" (P9).

Discussion

This study provides a unique qualitative exploration of women's experiences of an IE intervention during COVID-19, contributing to the scant evidence base to date. The findings highlight the overall positive experience of the Intuitive Eating model discussed by participants, as well as the varied facilitators and barriers to treatment during COVID-19. Prominent themes included the life-altering and self-exploratory experience of IE treatment, the liberation and challenges of COVID, as well as an acknowledgment of societal and social impacts on IE.

Key principles were highlighted by participants that affected the overall experience of the model and reflected the wide-ranging impact of IE treatment on their lives. '*Rejecting the diet mentality'* was described by many as the initial draw to IE and provided validation for their experiences of feeling 'mad' and 'miserable' around food prior to treatment. Through education on the diet mentality, which for many participants began pre-intervention via social media, the process of shifting internal blame for an inability to succeed at dieting to a failure of diet culture appeared to be supportive. Given the evidence base on the many psychological and physical harms of dieting (e.g. Bacon & Aphramor, 2011; Canetti et al.,

2002), it is perhaps unsurprising that anti-diet approaches to health are gaining global interest (Tribole & Resch, 2020; Tylka, 2006).

The process of developing unconditional permission to eat through the principle *'Making peace with food'* brought up more nuanced experiences. Increased time at home during the COVID-19 pandemic appeared to be particularly helpful in allowing participants to embrace aspects of permission to eat such as challenging forbidden foods and exploring new recipes and experiences. Further, participants development of increased pleasure around food, linked with principles such as '*Discover the satisfaction factor*' were richly described throughout interviews, and also appeared to be facilitated by the significant changes in lifestyle, such as increased time at home due to the pandemic, experienced by most participants. The many experiences of releasing external rules, noticing underlying thought processes, emotions and bodily sensations, and ultimately developing trust between brain and body are consistent with the process of developing improved interoceptive awareness, thought to be the underlying mechanism of IE. Although not directly measured in the present sample, research has shown that intuitive eaters display higher interoceptive awareness and experience increased body appreciation, psychological wellbeing and self-esteem, elements of which can be observed in the experiences of the present sample (Linardon & Mitchell, 2017; Oswald et al., 2017; Tylka & Kroon Van Diest, 2013). Overall, participants conveyed the radical and transformational experience of receiving IE treatment.

However, developing unconditional permission was also highlighted as incredibly challenging, similar to the experience of participants in the qualitative study by Barraclough et al. (2019). In order to support clients with adherence, Barraclough and colleagues suggest ample time be given to the principle during treatment to support integration and practice, as well as ongoing assessment of participants' ability to release the diet mentality to monitor for potential additional support. One method of measurement could be the Intuitive Eating Scale-2 (Tylka & Kroon Van Diest, 2013), a validated instrument which measures adherence to IE principles and the development of interoceptive awareness. Nonetheless, these

suggestions do not appear to go far enough, given the main barriers described in both Barraclough et al. (2019) and the present sample were fears around gaining weight, and in particular, how society might respond to this weight gain. Interestingly in the present study, participants described a protection from 'the gaze of others' facilitated by more time spent at home and less time socialising during the pandemic as a helpful factor in their IE treatment. The underlying message from participants was that with less scrutiny from the outside world, their sense of self and body image felt more protected and body neutrality was able to be practiced and embodied.

Some of the challenging societal impacts during COVID were discussed. Within the UK, for example, government messaging throughout the pandemic has included tackling obesity by encouraging dieting and calorie counting (Tackling Obesity, August 2020), with government currently attempting to pass legislation on including calorie counts on menus, despite evidence that these can be harmful, particularly for those with eating disorders (Simpson & Mazzeo, 2017; Tomiyama et al., 2013). One participant spoke to this directly: "When the government brought out their, I guess, fat shaming people and saying that they were causing COVID and you're gonna die, on the one hand, the body neutrality has been easier, but then, I think challenging the diet police and diet culture challenge has been much harder because there's been so much of it around. Especially when they did that big news release that said if you're overweight, it's their fault that COVID hit us…it reinforces the view that you're not a good person if you are overweight. And then there is that low grade worry that am I gonna die if I catch COVID? When they sort of came out and said everyone should lose weight, it's really hard to say actually this is big diet culture at play" (P11). One of the problems embedded in these campaigns is the focus on individual responsibility to manage weight, which ignores the role of genetics (Stunkard et al., 1990), the social determinants of health such as poverty (Irwin et al., 2006) and the industrialised food environment (Hall, 2018) amongst other factors, resulting in campaigns that can be experienced as shaming of those in larger bodies. The 'cultural challenges' of IE were also highlighted by Erhardt (2021)

with participants describing the ongoing process of navigating and resisting diet culture-permeated narratives in society and fearing the judgement of others for doing so.

Alongside concerns about societal effects on treatment, participants queried how their relationship to food would be impacted by COVID if they were not in treatment. Emerging research has explored the impact of COVID on eating disorder symptomatology. During the early stages of the initial UK lockdown, 87% of participants in one study of those who either were recovered from or had current eating disorders experienced a worsening of eating disorder-related symptoms, and for 30% symptoms became 'much worse' (Branley-Bell & Talbot, 2020). Lack of control and social support and increased rumination and social isolation were posited as mechanisms leading to deteriorations in mental health. Another study recruited participants with eating disorders from the US and Netherlands between April and May 2020, finding increases in anxiety, restriction and binge-eating episodes (Termorshuizen et al., 2020). Positive experiences were also expressed such as increased connection with family, self-care and motivation for recovery. Other recent data from the general population identified themes of loss and uncertainty about the future during COVID (Williams et al., 2020).

Outcomes from the present study bare similarities to this data: challenges with feeling out of control, being isolated, rumination and anxiety, and benefits of spending time with partners or family, developing new self-care strategies and for some, being motivated by COVID to seek IE support were all discussed. These findings mirror the importance of connection described by participants in the present study, whether with those around them or with the wider IE community via social media. Importantly, however, in contrast with the data, the majority of participants described little to no direct impact on increases in disordered eating, with many describing a reduction in their eating difficulties during their treatment despite the impacts of COVID: "I haven't had a single binge-eating experience at all since I've been doing the sessions and since I've finished" (P3). With emerging evidence as to the effectiveness of IE, including specifically for binge-eating disorders, it is

encouraging that participants reported improvements in their disordered eating and mental health given the broader COVID context (Burnette & Mazzeo, 2020; Kristeller & Wolever, 2011).

Limitations and directions for future research

This study is the first to examine the experience of receiving an Intuitive Eating intervention during a pandemic with associated lockdowns, consequent isolation and in some cases, difficulty accessing food. Some of the key limitations of the research involve sampling. For example, all participants were recruited from the same relatively small private clinic. Although an important aspect of the study design, which ensured that participants received treatment from IE-adherent specialists and thus fidelity to the model was retained, there were also drawbacks to this approach. Importantly, diversity of ethnicity, socio-economic status and gender identity, amongst other 'Social GRACES' (Burnham, 1992) were not achieved in the sample, hence it was not possible to sample those who have been under-represented in IE research. To date, the majority of IE research has been conducted with cisgender white women in the United States (Bruce & Ricciardelli, 2016), and it is imperative that further research continues a more recent trend of increased sample diversity (e.g. Burnette & Mazzeo, 2020; Hazzard et al., 2021) to ascertain whether IE treatment is culturally competent and acceptable (Sue et al., 2009). If diverse populations are not being offered or seeking IE treatment, perhaps due to accessibility or through choice, this should be investigated. This is a particularly important area of research to explore given the unique challenges that are often faced by marginalized communities, such as specific societal pressures (Costa et al., 2014), meaning that we cannot assume that themes generated from this white, female sample will be generalisable to their experiences. In addition, although a number of participants self-defined as living in larger bodies, the present study did not screen for body diversity; the differences in experiences of IE for those living in 'straight-sized' vs larger bodies would be of interest for further research, given the relevance of weight and body image raised throughout the study.

Recruiting participants independently via social media as in other studies (e.g. Erhardt, 2021) might have circumvented some of these limitations, and can be a useful strategy for targeted recruitment in a short space of time. There are some difficulties with this approach that may affect the quality or safety of the research, however, such as inability to ensure that participants have received accredited IE treatment and relying on participants' views as to whether they are experiencing an active eating disorder. In addition, participants who do not use social media could be inadvertently excluded from the study. However, future research may consider a mixed-recruitment strategy if challenges with sample size or diversity were pertinent.

Due to the self-selecting nature of the sample, it is possible that data may be positively biased toward participants who were engaged with and had positive experiences of their IE treatment with the LCIE. As clinicians acted as initial gatekeepers to recruitment, participant hesitancy at being in contact with the treatment provider may have deterred those who had dropped out or found IE ineffective from taking part. In addition, there may have been inadvertent or explicit clinician bias, where only participants who they felt would speak favourably about IE were selected to be contacted. In hindsight, it might have been helpful to support the service to generate a list of participants who met study criteria and advocate for a systematic contacting system; this may have provided some clarity and minimized the risk of potential inadvertent exclusion of participants.

Finally, despite some homogenous participant characteristics, such as gender, ethnicity and treatment institution, it is possible that the sample was not homogenous enough given the relatively small sample size. For example, there was a lack of homogeneity in participant treatment journeys, with participants recruited at differing stages of intervention as well as pre- or peri-pandemic, meaning that some began their sessions face-to-face and others only experienced online treatment. Although data saturation was reached within the sample, as no further themes were developing from later participant interviews, it may have been more methodologically sound to interview more participants

given the heterogeneity of the sample (Guest et al., 2006). Although this was not possible in the present study given time constraints and the challenges of recruitment during COVID, further research could consider issues of homogeneity such as ensuring that all participants complete IE treatment prior to research commencement, and may explicitly explore experiences of treatment differences such as online vs face-to-face. In addition to challenges with recruitment, time constraints on the present project impacted other areas of study design such as the inability to involve service users in the development of the interview protocol, or to provide member checks on data generated from interviews. The involvement of service and study participants in these ways can support with trustworthiness of the data, where researcher bias could impact data outcomes (Nowell et al., 2017).

Although generalizability of data should not be assumed and is not aimed for in qualitative research (Leung, 2015), it is striking that within the limited qualitative evidence base to date, including Barraclough et al. (2019) and Erhardt (2021), many similar themes and experiences were expressed by participants. This may reflect the robustness of the findings and areas of replication (e.g. studies with predominantly white, western women). Although a thorny issue in qualitative research, it may be important to reflect further on the utility and implementation of practices to aid generalized inferences from qualitative methods, given the importance of evidence-practice links (Polit & Beck, 2010). Nonetheless, a depth of understanding of this particular sample was achieved and is lacking in the current evidence base. As much of the current evidence base for IE is quantitative, it is hoped that the present study has demonstrated the value of an inductive approach to understanding experiences of IE treatment, using participants' own words, that would have otherwise been inaccessible through quantitative methods alone. Future studies should draw upon mixed-methods, longitudinal designs with a broader, more diverse sample in order to ascertain treatment effectiveness as well as acceptability.

Clinical implications

The findings of this study highlight some considerations for a number of settings. However, given the context of the present study as a small-scale single study, all clinical implications are tentative and require further evidence before clear recommendations can be advised. Nonetheless, for those working with IE clients, explicit support with the processes of IE such as considering a return to dieting may be considered to bolster clients' self-confidence to continue to engage with treatment, given the frequency with which these experiences occurred in the data. Normalisation in sessions or through peer support could be a way to help those navigating this process. In addition, acknowledgement of paths into IE which may not mirror dominant narratives of intensive dieting or exercise could be considered, particularly when providing resources or tasks for clients to attempt, as highlighted by some participants in the study. Finally, intersections with the challenges of COVID (isolation, mental health difficulties, lack of structure and loss of activities) could be considered as risks for challenges with eating under 'normal' circumstances.

The significance of support when undergoing IE treatment was described throughout interviews. Although one-to-one work with IE practitioners was highly valued by participants, additional group peer support could be considered, particularly for those feeling isolated during treatment. A further way to trial this could be by training IE 'Experts by Experience' to facilitate spaces for support as well as contributing to co-production of IE treatment. This model of peer support has proved successful in a multitude of healthcare settings by both democratizing treatment experiences and increasing the self-esteem of those participating (Mayer & McKenzie, 2017). Likewise, consideration around involvement of friends and family in treatment could be addressed. In combination with supporting participants to discuss IE with those close to them, inviting key members into a treatment session or offering an education and support session could be investigated.

Many of the challenges described by participants had clear intersections with wider societal attitudes toward health and/or weight. As psychologists and allied health professionals, it is our responsibility to engage in conversations in our field and with

colleagues about IE and weight-inclusive approaches to health, to minimize the risk of experiences such as the following: “I'm dealing with these health issues, my doctors giving me a list of foods not to eat, telling me to do diets and stuff, what do I do?” (P6). Training and support for colleagues in primary care and schools in particular could minimise harms of diet-influenced advice and aid in the crucial identification and delivery of interventions for eating difficulties (Currin & Schmidt, 2005). Given the burgeoning evidence base for the effectiveness and acceptability of IE (Bruce & Ricciardelli, 2016) and the risks of disordered eating becoming more serious and costly (Shisslak et al., 1995) the NHS and other statutory services could consider IE as part of a wider treatment package for eating difficulties. For example, IE programs in schools could be trialed to ease the burden on the NHS, given recent research on the prevalence of weight-control behaviours in adolescents (Hazzard et al., 2021). Further research on the implementation of early intervention strategies to combat eating and body image difficulties would have far-reaching benefits for both human and service costs (Austin et al., 2021).

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Part 3: Critical appraisal

Introduction

This critical appraisal will reflect the experience of developing the research and the specific impacts of COVID-19 on this process, before focusing on pertinent issues that arose during the recruitment and sampling, interviewing and analysis stages of the study. Reflections are aided by a reflexive research journal kept throughout the process of my doctoral research journey.

Preliminary research stages and the impacts of COVID-19

Throughout my doctoral training the process of developing a research project was challenging. My initial project involved investigating adolescent experiences of trust in therapeutic relationships. Unfortunately the student that would be supporting with recruitment of the project left the course and the project no longer felt viable to work on alone (significant challenges with recruitment were already being experienced on the project). Simultaneously, I became aware of a trainee who was involved with a project on Intuitive Eating (IE) in a CAMHS service. I had come across IE myself a few years prior through following accounts on social media that began to discuss non-diet approaches to wellbeing, and had explored it further through books and following UK-based practitioners such as Dr. Laura Thomas, who had written a popular book on IE, 'Just Eat It' (Thomas, 2019).

I began to incorporate the practices into my life with support from (non-IE centered) therapy. In addition, much of my prior work pre-training involved working with children and adolescents. I had seen first-hand through my work the number of young people who had eating difficulties and body image challenges which were significantly impacting their lives. I also experienced a lot of frustration when my attempts to refer them for specialized support for these difficulties, either to eating disorder services or mental health nursing support, would often be rejected due to lack of symptom severity or BMI being considered in the 'normal range'. An awareness of the barriers to support and a gap in treatment, or

availability of early intervention for eating difficulties, meant that I had considered the potential role for IE in the health system, pre-dating my knowledge of this project.

I was therefore incredibly keen to become involved with the project, and managed to join as the qualitative arm of the research. The project involved piloting an IE group for adolescents in a CAMHS eating disorder service who had already received treatment for their eating disorder but were experiencing residual symptoms of difficulties with their relationship to food and their bodies. Given the paucity of research in this area, its novel implementation in an NHS setting and the development of collecting pertinent, mixed-method evidence, I was incredibly excited at the prospect. My trainee colleague and I had worked on and submitted NHS ethical approval for the project and were beginning to work on the intricacies of recruitment and implementation when the pandemic occurred.

As the impacts of COVID-19 became clear, it slowly became apparent that it would not be possible to continue with the research. This was incredibly disappointing – all the excitement that I had felt at the importance of this research and the work that had collectively been put into setting it up felt like it was taken away overnight. Through conversations with the CAMHS team, who felt unable to ensure that we could conduct the research within appropriate time-limits for our doctoral training, and my supervisor, we agreed to halt work on the project. I therefore dauntingly found myself in the position of having to develop a new research project from scratch almost two years into my three year doctorate, and write up my third round of proposals and ethics forms. I was clear that I wanted to continue to investigate experiences of IE. Fortunately Laura Thomas was involved in the original CAMHS project, and I approached her to see whether it would be possible to recruit for a new study from her IE practice, the London Centre for Intuitive Eating (LCIE). This was ultimately agreed, and I began working on setting up this new study.

The impacts of COVID undoubtedly influenced my research experience and the development of the new project. Personal experiences of increases in stress, anxiety and uncertainty added to the challenges of developing the research, mirrored in COVID-related

experiences in the general population (Williams et al., 2020). Simultaneously I was on placement in a forensic unit, where we were navigating the challenges of PPE and patient hospitalisations and deaths due to the pandemic, and I also experienced a personal bereavement during my final year on the course. Navigating this period of time therefore required significant support from family, friends, colleagues and my supervisor. Although challenging, these experiences led me to wonder how COVID might be impacting on people's lives and experiences in myriad ways, including how this would affect undertaking an IE intervention, and perhaps supported me in my sensitivity when interviewing participants on their own challenging experiences of COVID.

Recruitment and sample

Although ultimately successful, recruitment to the study was challenging and took a number of months to establish. The main barrier to recruitment appeared to be busy clinicians remembering to contact prospective participants. Given the context of COVID and a significant reported increase in referrals to their service, it was understandable that the present project was not always a central priority for the service. It therefore felt crucial throughout the recruitment process to ensure that clinicians understood the project and their role in it, with plenty of opportunity for questions (I attended team meetings and had individual meetings with my key contact at the service). Further, I drafted scripts and emails that clinicians could amend as appropriate to send to potential participants, and sent out monthly reminders to keep the research in clinicians' minds. It is therefore possible that those who ended up participating in the study were clients who had better relationships with the service, clinicians and/or were motivated by positive experiences of IE, which may have influenced the findings. In addition, recruiting from one, relatively small service put some pressure on the process, as if a significant number of participants declined to take part or withdrew consent, the sample size might not have been viable.

One of the limitations of the present research is the lack of homogeneity in participants' treatment journey. For example, some participants were still having sessions

whilst others had finished a number of months ago. The lack of consistency in this respect was partly a practical response in order to meet sample size requirements, but may have masked differentiation of experiences within the group beyond the fact that some participants had not covered all IE principles in their treatment. For example, were there experiences specific to those who had started treatment pre-COVID compared to peri-COVID, or for those who may have started face to face and had to move their treatment online? It is possible that throughout interviews and during analysis, I did not pick up on and represent the variation in these experiences.

Interviews

Prior to interviewing I set up a bracketing interview with one of my trainee colleagues, aware of the importance of reflecting on my own stance in relation to the topic. The use of bracketing in qualitative studies can support the researcher to become aware of what they are bringing to the research, including their life experiences, cultural factors and expectations from the research (Fischer, 2009). This process brought up a number of factors to think about. For example, I became aware of my clear vested interest in wanting to 'evidence' the utility of IE, given the lack of research to date and my own personal experiences of valuing IE. I became aware of how important it would be for me to consider the impact that this may have on how I navigated interviews. Through these reflections and the use of my research journal, I ensured that I checked in with how much opportunity and time I was facilitating in interviews for participants to share their less positive experiences of IE, which may have been more challenging for participants anyway given potential loyalties to the clinic and practitioners. It would have been useful, as Fischer (2009) notes, to have continued to bracket in a more formal way throughout the research process in order to reveal continued assumptions that may have influenced data analysis and write up of the research.

The process of interviewing occurred over a few months which allowed some space between interviews to reflect on the experience. Ensuring significant periods of time between

interviews were minimized, as much as was possible, meant that I developed a good grasp on how the data were developing interview by interview, and supported with a sense of when data saturation was reached (Ando et al., 2014). I had previously worked as a qualitative researcher so had some relevant experience (interviewing both via phone and face to face), but nonetheless found that my confidence grew over the course of interviewing as I became more comfortable and flexible with my semi-structured interview protocol, using my research journal to guide this process.

Some of the reflections that I kept track of involved how researcher characteristics may impact the data. Age, for example, came to the forefront of one interview as the participant described to me how she interacted with friends: “Like before…pre-mobile phones (laugh). I have no idea how old you are” (P7). As a 29-year-old woman, I may have been experienced by some participants as a ‘peer’ or by others as a younger ‘student’, perhaps, who may not understand participants’ points of reference or experiences. These perceptions could have supported or hindered how the data unfolded; for example, similarities in characteristics could mean participants felt more comfortable sharing their experiences, but could also lead to a false sense of shared understanding and to a lack of clarification of experiences from either researcher or participant. Although it can be challenging to keep a number of elements in mind whilst interviewing, it was helpful to reflect on these processes to ensure that I sought clarification from participants if I felt this dynamic was occurring.

The context of COVID had a significant impact on how interviews were to proceed, with the option of face-to-face interviews removed. Participants were given the option of video-call or phone interviews; all agreed to video interviews, although a few had to be conducted via phone or audio-only due to poor internet connection. Technology difficulties were a source of anxiety at times and caused some initial interruptions to interviews, although were ultimately able to be resolved. However, the flexibility of interviewing participants from home appeared to be convenient for both parties, and may have facilitated

study recruitment. Krouwel et al. (2019) compared face-to-face and video-call methods of qualitative research interviews, finding that although there may be some additional benefits to face-to-face interviewing (participants tended to say more than when using video-call methods), they did not outweigh the significant benefits to time and budget common across qualitative studies. Further, researchers in the study did not report experiencing significant variations in ability to build rapport with participants across the two methods, which mirrors my experience of the ease at which rapport was able to be built with participants in the present study. The increasing move to online methodologies, significantly driven at present by the restrictions of COVID, may mean that increased flexibility and choice is offered within research studies in the future.

Analysis of data

Although I had prior experience of qualitative research, particularly interviewing, I had less experience of analyzing qualitative data (I had conducted an Interpretative Phenomenological Analysis for a Masters course a number of years ago). It was therefore equally intimidating and exciting to embark on the analysis process of developing themes from the data.

Much of the existing research on IE is investigating effectiveness of the treatment, rather than exploring participants' unique experiences of IE. I felt that using a qualitative design would add richness to the current understanding of experiences of IE. Indeed, I found that I had gathered a lot of rich data from participant interviews, which of course aided the development and generation of themes, but also meant that it took some time to amalgamate clear and coherently defined domains. Adhering to Braun and Clarke (2006)'s stages of thematic analysis supported me in this process, as did referring to Saldaña (2013)'s work on coding. Throughout the process of interviewing and analyzing data, I was keen to employ a 'bottom-up', inductive approach to the data, to allow for utterances or themes to develop that were not theory-driven (Boyatzis, 1998). The 'flexible rigour' of

thematic analysis was therefore appealing for the present project compared with other qualitative techniques which may require more epistemological purity.

Further, ensuring quality data were produced from my thematic research was a key part of the process; for example, referring to Tong et al. (2007)'s Consolidated Criteria for Reporting Qualitative Research (COREQ) framework supported me to adhere to best practice in qualitative research where possible. For the present research, some of these checks during the analysis stage included two independent researchers coding data as a credibility check (Barker & Pistrang, 2005) and reporting a clear process of deriving themes from the data as opposed to a pre-identification of likely themes (Braun & Clarke, 2006). Utilising these key texts to inform my analysis helped to manage the inevitable anxiety that arises when encountering a rich data set and helped to hone my skills as a qualitative researcher.

To conclude, the process of conducting the present research during COVID-19 was challenging but informative. Navigating recruitment, interviews and analysis during this period brought up the need for flexibility and responsiveness in the face of external events, and the experience has supported me to feel more confident in my abilities as a clinical researcher.

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Appendices

Appendix A: Participant Information Sheet

UNIVERSITY COLLEGE LONDON

Research Department of Clinical, Educational and Health Psychology

Research Department of Clinical, Educational and Health Psychology

University College London

Gower Street

London WC1E 6BT

Tel: X

Researchers:

Ms Grace West-Masters, Principal Investigator

Dr Lucy Serpell (Clinical Psychologist & UCL Chief Instigator)

Collaborators:

Dr Laura Thomas (Registered Nutritionist, Director and Lead Nutritionist at the London Centre for Intuitive Eating)

Ms Rhian Houghton (Registered Dietitian at the London Centre for Intuitive Eating)

Email: X

Research Study – Participant Information Sheet

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Investigating the experience and acceptability of Intuitive Eating (IE) in an adult population during COVID-19.

UCL Research Ethics Committee Approval ID Number: 18501.001

You are being invited to take part in a research study. The research is a component of the researcher's Doctoral training in Clinical Psychology at UCL. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

What is the purpose of this study?

We are interested in exploring how people have experienced using an Intuitive Eating (IE) approach during COVID-19 and the country-wide movement lockdown. The study has been designed to understand whether participants have felt able to engage with IE during this time period, what has made it easier or harder at this time, and whether people are likely to continue to use IE after the pandemic eases. To do this we will meet with you virtually through online video methods or phone to discuss your experiences.

Why have I been invited?

You have been invited to take part in this study as you have received an Intuitive Eating intervention with the London Centre for Intuitive Eating (LCIE). The study is appropriate for those over the age of 18. Unfortunately this study is not recruiting participants who have a

current, active eating disorder as diagnosed by a healthcare professional. This study aims to recruit between 10 and 12 participants over the course of the study.

What will happen if I take part?

You will be invited to take part in the research by a member of the London Centre for Intuitive Eating team who will provide you with verbal information about the research and this Participant Information Sheet and attached Consent form. If you agree to take part in the research, you will then be contacted by Grace West-Masters to arrange a convenient time to meet virtually, either via video methods (Microsoft Teams) or over the phone. The interview will explore your experiences of using IE during COVID-19. It will be one-to-one and will typically last around 45 minutes.

If you decide not to take part in the study you can withdraw at any time without giving a reason, and without it affecting any current or future care you receive from the LCIE. If you do decide to take part in the study, any feedback will be anonymised and no identifying information will be shared with the LCIE. The research undertaken for this study is independent of the LCIE who will not have access to non-anonymised data. The LCIE will therefore not know what you have said about your experiences of using Intuitive Eating.

Will I be recorded and how will the recorded media be used?

Interviews will be audio recorded. The audio recordings of interviews during this research will be used only for analysis of this research project. No other use will be made of them without your written permission, and no one outside of the UCL research team will be allowed access to the original recordings. The original recordings will not be shared with the LCIE team. The recordings will be stored securely on password protected computers and devices, and will be destroyed following anonymous transcription (i.e. when the audio recordings are written up).

What are the possible disadvantages or risks of taking part?

All the methods we use are non-invasive and normally cause no harm or distress. However, the research team will be able to offer advice and support should you become unexpectedly

distressed during the research process. Please note that involvement in the study will require a potential cost of your own time.

If at any point during or after participation you become concerned about your relationship to food, please speak with your LCIE practitioner, contact your GP or contact BEAT eating disorders charity https://www.beateatingdisorders.org.uk/.

What are the possible benefits for taking part?

Whilst there are no immediate benefits for those participating in the research, it is hoped that this work will help shape our understanding of Intuitive Eating and lead to future research. There is not yet very much research into Intuitive Eating, and no research has so far looked into the experiences of IE during a time like the UK-wide COVID-19 lockdown. Your participation will help to contribute to developing the use IE for people in general, and could help us understand what parts of IE may be easier or more difficult to keep going during other periods of crisis, anxiety or stress in individual's lives. Further, research outcomes may indicate the need for research in areas which show parallels to the COVID crisis.

We hope that the interview will give you an opportunity to reflect on your own experience of using IE.

Expenses and payments

A £10 voucher will be provided for participation in the research.

What do I have to do to take part?

After reading this information sheet, you may discuss the study with us or with friends and family if you wish. If you are interested in taking part in the study we will ask you to provide informed consent, which means that you understand the purpose of the study and what is going to happen. After giving consent and signing the attached consent form, we will arrange a time to conduct the interview of your experiences. You will be able to leave the study at any point without having to give a reason.

What happens to the results of the research study?

All information will be kept strictly confidential. Data will be identified by a code number only, and will be kept on a password-protected computer. This data will be held by UCL for the duration of the study and the analysis of its results. We plan to publish the results in a scientific journal. We will give you a copy of the published results upon request. In the event of an audit, responsible members of University College London (UCL) may be given access to data for monitoring and/or audit of the study to ensure we are complying with regulations. Please check the "What will happen to my data?" section for more information on this.

If you decide to withdraw from the study within four weeks of the interview taking place, all recordings and transcripts of the interview would be destroyed. After four weeks post-interview, data would be included in research analysis.

Voluntary Participation and Discontinuation

Your participation in this study is voluntary. If you agree to take part and then change your mind and wish to withdraw you may do so at any time without this decision affecting your current or future care at the LCIE. If you decide not to take part your treatment within the LCIE, if applicable, will continue as normal. Your legal rights will not be affected by your giving consent to participate.

What will happen to my data?

Data protection regulation requires that we state the legal basis for processing information about you. In the case of research, this is 'a task in the public interest.' University College London is the data controller and is responsible for looking after your information and using it properly.

We will be using information from you and will use the minimum personally identifiable information possible. In line with UCL policy, we can store research data for up to 20 months after the study has finished, but no longer than is required for findings to be written up (Doctoral thesis, journal articles) and disseminated.

Data protection regulation provides you with control over your personal data and how it is used. When you agree to your information being used in research, however, some of those

rights may be limited in order for the research to be reliable and accurate. Further information about your rights with respect to your personal data is available at

https://www.ucl.ac.uk/data-protection/data-protection-overview

Notice:

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in health and care research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data are: 'Public task' for personal data and' Research purposes' for special category data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

You can find out more about how we use your information by contacting Grace West-Masters (see below) or Alex Potts, UCL Data Protection Officer (a.potts@ucl.ac.uk).

Who is organising, funding and monitoring the research?

The research is a component of Grace West-Masters' Doctoral training in Clinical Psychology at UCL. It is not funded by any grants or awards. Investigators will not receive money for recruiting you into this study.

The study proposal has been reviewed by the UCL Research Ethics Committee and was given a favourable opinion.

What if something goes wrong?

University College London, as Sponsor, has appropriate insurance in place in the unlikely event that you suffer any harm as a direct consequence of your participation in this study.

However, if you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the University Joint Research Office here https://www.ucl.ac.uk/joint-research-office/contact-us. Alternatively, you may contact the senior adviser of this study, Dr Lucy Serpell (chief investigator) or the UCL Ethics department (ethics@ucl.ac.uk).

Safeguarding and Confidentiality

All information from this study will be kept strictly confidential. The only exception to this is if a participant in the study expresses possible risk to themselves or others (including safeguarding issues). Should a possible risk or safeguarding issue be raised within the study the researcher will restate the boundaries of confidentiality and the possible consequences of making a disclosure.

How to contact us:

If you would be willing to take part in this study, or would like to discuss the research further with someone, please contact Grace West-Masters or Dr. Lucy Serpell at the following:

Research Department of Clinical, Educational and Health Psychology

University College London

Gower Street

London WC1E 6BT

Tel: X

X

X

Thank you very much for considering taking part in this study!

Appendix B: Participant consent form

UNIVERSITY COLLEGE LONDON

Research Department of Clinical, Educational and Health Psychology

Research Department of Clinical, Educational and Health Psychology

University College London

Gower Street

London WC1E 6BT

Tel: X

Researchers:

Ms Grace West-Masters, Principal Investigator

Dr Lucy Serpell (Clinical Psychologist & UCL Chief Instigator)

Collaborators:

Dr Laura Thomas (Registered Nutritionist, Director and Lead Nutritionist at the London Centre for Intuitive Eating)

Ms Rhian Houghton (Registered Dietitian at the London Centre for Intuitive Eating)

Email: X

Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts data-protection@ucl.ac.uk

Research Study – Participant Consent form

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM

Investigating the experience and acceptability of Intuitive Eating (IE) in an adult population during COVID-19.

UCL Research Ethics Committee Approval ID Number: 18501.001

Please complete this form after you have read the Information Sheet.

Thank you for considering taking part in this research. The person organising the research (Grace West-Masters) must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction and would like to take part in an individual interview.	
2.	I understand that I will be able to withdraw my data up to four weeks after interview, but that after this point data would be included in research analyses.	
3.	I consent to participate in the study. I understand that my personal information regarding my experiences of using Intuitive Eating during COVID-19 will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing, 'research purposes' will be the lawful basis for processing special category data.	
4.	**Use of the information for this project only** I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand that my data gathered in this study will be stored pseudo-anonymously (participants will be identified with a unique participant ID) and securely. It will not be possible to identify me in any publications.	
5.	I understand that my information may be subject to review by responsible individuals from the University for monitoring and audit purposes.	

6.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I understand that if I decide to withdraw, any personal data I have provided up to that point will be deleted unless I agree otherwise.	
7.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
8.	I understand the indirect benefits of participating.	
9.	I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	
10.	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
11.	I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No	
12.	I consent to my interview being audio recorded and understand that the recordings will be destroyed immediately following transcription.	
13.	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet ('Why have I been invited?') and explained to me by the researcher.	
14.	I hereby confirm that: (a) I understand the exclusion criteria as detailed in the Information Sheet ('Why have I been invited?') and explained to me by the researcher; and (b) I do not fall under the exclusion criteria.	

15.	I am aware of who I should contact if I wish to lodge a complaint.	
16.	I voluntarily agree to take part in this study.	

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix C: Semi-structured interview protocol

• When did you access an IE intervention with the LCIE?

• What led you to access the LCIE for an IE intervention?

• Were there principles of IE that you liked and/or found helpful? If so, which? Why do you think this was?

• Were there principles of IE that you didn't like and/or find helpful? If so, which? Why do you think this was?

• (As applicable) Are there differences with how you have implemented IE during the COVID-19 lockdown compared with pre/post-lockdown? Why do you think this is?

• Were there principles of IE that you have found easier to use during lockdown? If so, which? Why do you think this was?

• Were there principles of IE that you have found harder to use during lockdown? If so, which? Why do you think this was?

• Have/will you continue(d) to implement the IE approach post-lockdown? If yes, why? If no, why?

• Would you recommend IE to others?

• Any other comments?

Appendix D: Example of an analysed transcript (P1)

GW: And maybe just thinking back as well, like when you were kind of first reading Laura's book or the intuitive eating book by Evelyn. Was there anything that you remember kind of reading that you were like I don't know I'm not sure about that that bit?

P1: So, definitely when I read the whole of Evelyn's book, I was like you know, this sounds great in practice and theory, but there is no way, I feel like, there is no way I can do this in practice. [LOGIC VS EMOTION]. It's not gonna work. I don't see how… And it's having that lack of trust in myself. [LACKING TRUST IN SELF]. It was that I don't see how I can let myself eat what I want because if I do that then I'll just eat nothing but crisps and chocolate for the rest of my life. [FEAR OF LOSING CONTROL]. So, and that is one thing I think has been really useful in getting the support. It's helping me realise that that's… It is possible. But definitely reading the whole of Evelyn's book, I was just like, it is great in theory, but it's kind of wishful thinking almost. I'm trying to say I don't know that there is… Again, I don't know that there is any sort of specific bits wrote at all. I love the idea. I can definitely do that, but this particular part give us just that general feeling of, yeah, I wish I could just do what I want.

GW: So, it kind of felt in some ways a little bit unattainable and unrealistic?

P1: Definitely. And also, I think it felt like the kind of thing that I definitely couldn't do myself like, I would like… It's like, oh, it's all very well and good for these people that are coming along to their clinics and like their actual clients, but for, like, me sitting here…and I was reading on the bench in my garden this summer. It was really nice. Like, me sitting in my garden, reading this book, like there's no way I can do any of this. [NEEDING SUPPORT TO USE IE].

GW: And how is… Has that changed since you started the one -to-one?

P1: Definitely changed since I started with [IE practitioner]. Particularly around the chocolate orange exercise, like that, I think, that definitely showed me that it is possible, I can… My

brain and my body can trust each other. I think that's been a massive step forward, in terms of like trust in the process and things [DEVLEOPING TRUST IN SELF] [BRAIN AND BODY TRUSTING EACH OTHER].

GW: I think that's something that you've been kind of saying throughout this whole interview. So far, it's something that kind of like brain-body connection and the trust, and that's been something that's potentially been the biggest thing that you've been working on.

P1: Yeah, cause I've spend so long, being told that I can't trust my body, like my brain can't trust my body to tell it when it's hungry and my body can't trust my brain to feed it when it's hungry. Like I spend so much money as well, it terrifies me to think how much money I spent on diets over the years. I put so much time and money and effort, believing that I can't trust myself around food. I'm really enjoying learning that I can, and that those signals and those bolts I have, are, I can listen to them. I'm not gonna… It's not all gonna go horribly wrong. So, I think that's definitely been my biggest takeaway to date [ENJOYING DEVELOPING TRUST IN SELF].

GW: So, the other things, I guess, to think about, which I'm wondering might be quite tricky because you have started your one-to-one sessions during lockdown, but it sounds like actually you were reading and thinking about intuitive eating before the start of this year, right? From what you've been saying. Cause one of the things that I'm wondering about people is whether there has been anything that's been easier to do in terms of intuitive eating and using the intuitive principles during lockdown periods and things that potentially been harder comparatively. So, I'm wondering whether that's an easy question to be able to be able to think about, because you've (…), because you have actually kind of been doing the work and it's all been through lockdown really.

P1:I think… So, I obviously don't have any like comparison to the one-to-one sessions outside of lockdown, but one thing I have thought, like, always… It's good that I'm doing this now, kind of thing, is that I'm much… And this is probably harking back to diet culture, but

I'm more in control at the moment of what I eat and what food I'm around and I can manage that relationship more easily, I think. Because I'm not at work every day, I'm not out and about, we're not going out for dinner or not doing it for lunch. We don't have, like family gatherings and not having to deal with external factors. It's just me and I'm in control of what food we bring into the house and all that sort of things. So, I think I've definitely thought a couple of times I'm quite glad about that. [MORE IN CONTROL] [NOT DEALING WITH EXTERNAL FACTORS] But then I suppose there's the flip side of…like about I'm missing out on learning how to deal with a number of situations that have been difficult for me in the past. With diet culture, socialising and stuff like that. So, I'm kind of missing out on addressing that side of it. [MISSING OUT ON LEARNING HOW TO DEAL WITH EXTERNAL SITUATIONS].

GW: Could you say a bit more about what situations have been harder for you in the past?

P1: Yes, so, under the… all under the sort of umbrella of socialising, but those situations where you are with friends in a restaurant, and you… like, the things you will do, like fill yourself up on fruit and veg and zero-point soup before you go for dinner so that you're not tempted by dessert and that sort of thing. Like, there's been countless occasions I've just flat-out turned down in the past, cause I'm like, there's gonna be food there. And I've got no… I've got no weekly points left, so can't possibly go to that. And my friend's 30th was… So, I went and they were obviously all eating and drinking and I took my wine measures with me and I kept tally marks on my phone so that I knew what I'd eaten and drunk and that sort of thing. And I think I could still be… Like, we haven't dealt with that, all, we haven't talked about that sort of thing. Obviously, there's the core principles like once you sort of nail that unconditional permission to eat, you can kind of take that and apply it to different situations. But I think that's one thing I'm aware of, I'm not really getting the opportunity to put that part into practice. [NOT DEALING WITH SOCIALISING ISSUES]. [NO OPPORTUNITY TO PUT INTO PRACTICE]. [CAN APPLY CORE PRINCIPLES TO DIFFERENT SITUATIONS]. I guess…And I guess coming up to Christmas as well. Christmas is going to look so different

for everybody and I'm so used to Christmas being like I'll lose as much weight as I can in the run up to Christmas. Do what you want for certainly two or three days before it. But then obviously you've not been eating anything, so those two or three day over Christmas you just go crazy and you binge, and you then feel guilty afterwards. So, I guess that not having…not being able to take what I've learned over the last sort of 8, 9 weeks and apply it in practice to a situation like Christmas that would normally be so… like, steeped in diet culture for me. And I guess that would be a downside. But like I say, I think it's giving me the time and the space to kind of focus on the basics. [TIME AND SPACE TO FOCUS ON THE BASICS]. And I guess this is a way of putting it. There is one other thing I thought of while I was talking. What was it? People. Other people, that's what it is. I'm not seeing other people. So, my mum's got a really bad relationship with food and her body. Obviously, I'm not seeing my mum at the moment and in the past, like, it's like little things like comments she made about me and obviously eating and stuff like that. So, I've taken myself out… society is taking that situation away from me, like, I can't see her, I can't spend time with her. So, I don't know if that's a good or a bad thing. Again, it's like the social situations…It's giving me time and space to deal with my own issues without having to deal with comments from family members and stuff. Yeah, at the same time it's not letting me put what I'm learning, sort of into practice in those situations. Yeah, I guess I can see upsides and downsides to it, but I suppose, [UPSIDES AND DOWNSIDES TO COVID] yeah, I think the main takeaway from it for me is that I'm quite glad that I've got the time and the space to work on myself, and then when things start to open up and get back to normal then I can… I'm more equipped to go and deal with the real world, the outside world. [TIME AND SPACE TO WORK ON SELF] [EQUIPPED TO GO OUT AND DEAL WITH THE REAL WORLD].

Appendix E: Extract of third stage of coding for analysis, 'Searching for themes'

THEME: Rejecting diet culture				
CAN'T UNSEE DIET CULTRE. LIGHT BULB SWITCHED ON/ NOTICING DIET CULTURE P1 I; P3 I; P5 II	BODY DOESN'T KNOW YOU'RE DIETING P1 I DIETING DOESN'T WORK P1 I	DON'T HAVE TO DIET/APPEAL OF NOT HAVING TO DIET/SICK OF DIETING/RELIEVED P1 II; P2 I ; P5 I; P6 I TRUSTING IE OVER DIET CULTURE/CAN'T SEE MYSELF DIETING AGAIN P3 I; P10 I	REJECTING DIET MENTALITY ENJOYABLE, FUN AND LIBERATING P1 I; P2 I	IE GAVE VALIDATION/ IT WASN'T MY LACK OF WILLPOWER OR MOTIVATION, IT'S JUST SCIENCE THAT DIETING DIDN'T WORK P1 II
MORE INFORMED, CAN IGORE INTERNAL DIET VOICE P2 I	CAN LISTEN TO DIET CHAT AND IT NOT BE A BIG DEAL P2 I PRACTICING NOT ENGAGING	ANGRY WITH DIET CULTURE P8 I	IE HAS REPLACED DIET CULTURE P6 I	GOT IT P7 I NOT HARD TO GET ON BOARD WITH P11 I

	WITH DIET CHAT IN SOCIAL SITUATIONS P5 I			

Appendix F: Extract of fourth stage of coding for analysis, 'Reviewing themes'

THEME: Discovery of self			
ENJOYING DISCOVERING FOOD PREFERENCES/TRYING NEW THINGS P1 I; P3 IIII; P4 II; P5 I; P8 I; P9 II FINDING PLEASURE IN FOOD WITHOUT GUILT/SHAME P2 I; P5 I; P6 I; P7 III; P9 II; P10 I COOKING NEW RECIPES/MEAL PLANNING/BECOMING MORE CONFIDENT P2 I; P4 II; P5 II; P8 I REDISCOVERING FREEDOM AND JOY	IE HELPS ME TO LEARN ABOUT MYSELF AND GET TO KNOW MYSELF/ LEARNING TO TRUST SELF/REFRESHING TO TRUST SELF/ GROWING MY CONFIDENCE BACK/LESS SELF-BLAME /KINDER TO SELF P1 IIIII; P3 I; P4 I; P5 II; P6 I; P7 II;P8 I; P9 II	IE WORK UNCOVERED SUBCONSCIOUS FOOD DIFFICULTIES /REALISED WAS IN DIET MENTALITY/REALISED WASN'T TRUSTING BODY/ NOTICED A BLOCK/ MORE WAS UNDER THE SURFACE THAN REALISED/ SEEM TO BE MANY LAYERS TO FOOD DIFFICULTIES EVERY TIME P1 I; P2 I; P3 III; P5 II; P7 III; P8 II; P10 I; P11 II	REDISCOVERING A RELATIONSHIP THAT I'D DESTROYED/ PROFOUND IMPACT ON RELATINSHIP WITH FOOD AND BODY P3 I; P8 II GETTING INTO NUANCED PARTS OF IE AND TWEAKING THINGS FOR ME P10 I

OF FOOD/COMFORT P3 I; P8 II; P11 I EMPOWERING TO LEARN WHAT I ENJOY AND MAKES ME FEEL GOOD P4 I; P7 I TESTING THINGS OUT/PLAYING AROUND/CHALLENGING SELF P7 III; P9 I; P10 II; P11 II FLEXIBILITY WITH FOOD/IE TOOLS P7 II; P8 I; P11 I			
IE POSITIVELY IMPACTED PHYSICAL AND MENTAL HEALTH P3 I	IE IN LINE WITH VALUES, FEMINISM/LOOKING FOR NEW	DISCOVERING BALANCE BETWEEN PLANNING VS RIGIDITY P7 I	ACTING FROM LOVE NOT FEAR AROUND FOOD P9 I

LESS DISSOCIATED WITH FOOD, REACT BETTER TO CHALLENGING LIFE CIRCUMSTANCES P7 I	FRAMEWORK P5 I; P6 IIII; P8 III; P11 IE AWARE WE ARE NOT OPERATING IN A VACUUM/ ABLE TO LOOK AT SOCIETAL INTERSECTIONS P6 II		

THEME: The pull of dieting				
WISH TO GO BACK TO DIETING, BUT IT'S HORRIBLE/CONFLICT P1 I	DRAW OF DIET CULTURE MIGHT TAKE HOLD AGAIN P1 I	FALLING BACK INTO DIET CULTURE IN SOCIAL SITUATIONS P5 I		

Subthemes identified:

Giving yourself permission is radical

IE is hard work

Letting go of external rules

Brain and body beginning to trust each other

Time and space to focus on self

Pressures on body image

Appendix G: UCL Research Ethics Committee approval of ethics application

UCL RESEARCH ETHICS COMMITTEE OFFICE FOR THE VICE PROVOST RESEARCH

02/10/2020

Dr Lucy Serpell

Clinical, Educational and Health Psychology UCL

cc. Ms Grace West-Masters Dear Dr Serpell

Notification of Ethics Approval

Project ID/Title: 18501.001 / Investigating the experience and acceptability of Intuitive Eating (IE) in an adult population during COVID-19.

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Joint Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **02/10/2021.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form' http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- • ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: www.ucl.ac.uk/srs/governance-and-committees/research-governance
- • note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research. Yours sincerely

Professor Michael Heinrich

Joint Chair, UCL Research Ethics Committee