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# The Lived Experience of Obese People Who Feel That They Are Addicted to Food

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**Abstract:** Aims: Self-perceived food addiction is a controversial and poorly understood concept. Little is known about how individuals experience feeling addicted to food and the possible role this plays in obesity. This study used a qualitative design to explore the feelings and behaviours of self-diagnosed food addicts and the impact this has on their attempts to lose weight. Methods: Semi-structured interviews were conducted with six obese, self-perceived food addicts. Verbatim transcripts of the interviews were then analysed using Interpretative Phenomenological Analysis (IPA). Results: There were four overarching themes 'I breathe food', which describes a life that has been completely overtaken by thoughts of food and uncontrolled eating; 'Isolation', feelings of being alone which are driven by experienced weight stigma, an inability to function in a food-obsessed world and having an addiction that is viewed as somewhat of a joke; 'Identity', how shame about weight and eating habits have meant that individuals feel as if they have lost their real selves and 'Diagnosis and treatment', a desire to have their perceived condition formally recognised in order to receive appropriate treatment, but without a clear idea about what form effective treatment would take. Conclusions: Uncontrolled eating and its related bingeing, grazing, obsessional thoughts, cravings and secret eating were all identified as evidence of being addiction to food. Although food addiction is not an officially recognised disorder, healthcare professionals working in this field should have an appreciation of the feelings of self-perceived food addicts and the barriers this can cause in losing weight and moderating eating behaviour amongst this obese population.

**Keywords:** Food, Eating, Addiction, Obesity, Qualitative, IPA

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## 1. Introduction

Nearly all food intake is associated with some degree of pleasure [1] and where food is plentiful and relatively affordable, eating frequently occurs in the absence of physical hunger [2]. A recent review [2] found that this hedonic hunger does not always lead to food consumption and is only weakly linked with obesity, but when other factors, such as impulsivity, are considered, hedonic hunger can lead to increased calorie consumption. Therefore, certain individuals are more influenced by food cues than others and factors such as mood can influence eating behaviour associated with obesity.

Individuals who are obese have been found to regulate emotions with food more often than their non-obese

counterparts [3]. A systematic review of the literature found that this was more pronounced in obese individuals who regularly binge eat [4]. Common emotions cited by obese individuals as triggers for emotional eating are stress, depression and sadness. Eating in response to negative emotions is associated with more unhealthy food choices [5]. Close [6] used an IPA approach to explore overweight women's experience of comfort eating. Participants in this study used eating to both escape from and change negative emotions but this led to feelings of shame and was a private and often secret experience. Participants also described an internal battle caused by ambivalence around eating; they experienced strong desires for food but also tried to resist because of shame around their weight.

The concept of hedonic hunger and may imply that obese

individuals are highly receptive to food cues which make weight loss difficult. A synthesis of findings [7] identified a number of perceived barriers and facilitators to weight loss. The availability of unhealthy food as well as social and cultural pressures to eat was cited as a barrier to many participants as well as eating for reasons other than hunger. Emotional eating was identified as a barrier to weight loss and was viewed as a factor that was out of an individual's control. Indeed, there seemed to be a split in participants' views on their ability to change their behaviours: patients who attributed their weight to physical or mental health factors (such as genetics or depression) believed their weight to be uncontrollable, whereas those who attributed it to behavioural factors (such as unhealthy food choices) viewed weight as a controllable factor that was their personal responsibility to change.

Similar findings can be seen in research on individuals' experiences of having bariatric surgery. In one study, obese individuals described feeling hopeless after countless failed diet attempts [8]. They did not believe that they had any control over their eating which led them to attribute their obesity to medical rather than behavioural causes. This, in turn, led them to seek a medical intervention (surgery) and they were keen to hand over control of the situation to a health care professional. Thus, it would seem that how individuals explain their obesity may have important implications for their help-seeking behaviour and self-efficacy with regards to losing weight. This is particularly pertinent to the concept of Food Addiction (FA), a contentious view that has received much attention in recent years [9] and which up to 52% of the population endorse [10], is considered: an addiction is widely accepted as a disease [11]. It is conceivable, then, that obese individuals who attribute their weight to an addiction may believe that their eating is out of their control.

FA is a concept that exists largely in the public domain. There are countless websites and books dedicated to the topic [12]. Resources such as this discuss FA as if it were a diagnosable condition and detail symptoms, causes, and treatment options. On top of this, the concept of 'detox diets' has become popular in recent years and many warn that symptoms such as fatigue, headache and bloating will occur due to sugar withdrawal [13]. The impact that the media has had on shaping the public's view of FA has not been researched in detail but one study found that after reading a bogus news article stating that FA was scientific fact, self-diagnosis was significantly higher than in those reading articles stating that it did not exist [14]. Those who believe they are addicted to food and are experiencing severe consequences, such as obesity and use these self-help treatments in place of professional medical support as their condition is not recognised by healthcare professionals.

In an online survey [15], 210 participants were asked whether they believed themselves to be addicted to food. Responses were thematically analysed and six themes emerged: reward-driven eating (emotional eating), preoccupation with food, lack of self-control, cravings, health

issues, and specific foods. These findings are not dissimilar to those found in qualitative research looking at unsuccessful dieters [16] that found overweight individuals who regained weight after dieting reported emotional eating and a perceived lack of control around food whereas successful dieters did not eat to regulate mood and believed that they were in control of their food intake. However, the methodologies used by Ruddock et al. [15] meant that they were unable to obtain rich, detailed accounts of the perceived characteristics of FA. Had they used a more in-depth design, they may have identified features that are unique to those who perceive themselves as addicted to food. Secondly, the study took a random sample of students, the majority of whom were of a healthy weight so this study could not reveal anything about whether the beliefs about FA posed a barrier to weight loss in overweight people. Thirdly, Byrne, et al. [16] used data from both addicts and non-addicts in the thematic analysis; hence, they were examining both the experience and the social perceptions of FA. This is not necessarily a bad thing, in fact, it is important to understand the influence the media has had on the general public. However, if we are interested in whether perceived addiction to food impacts individuals' ability to lose weight then we must disentangle the socially constructed view of food as an addiction to the lived experience of those believing themselves to be addicted.

The present study therefore aimed to address this shortage in the literature to further understand how obese individuals experience and make sense of their uncontrolled eating behaviours in the context of FA. An IPA study was undertaken with obese participants who believe they are addicted to food with the aims of investigating:

1. How uncontrolled eating manifests for them and how it has impacted on their weight
2. Which aspects of their eating behaviour they attribute to a food addiction and why
3. Whether the belief that they are addicted to food has impacted on any attempts to control their weight
4. Their views on whether FA should be a classified condition and how that would impact them
5. Treatment options they believe may be effective in helping them to lose weight.

## 2. Method

A semi-structured interview-based phenomenological approach was selected. IPA, as described by Smith, et al. [17] is a qualitative method that seeks to explore how people make sense of life events, and was therefore deemed appropriate for this study. IPA is concerned with how an individual attempts to make sense of significant life experiences.

### 2.1. Participants

Participants were recruited through a Tier 3 weight management service. This meant that all participants had a

BMI of over 40, had failed to lose weight on at least one Tier 2 programme (e. g. Slimming World, Weight Watchers.), and had been put forward for bariatric surgery. Eating disorders are part of the exclusion criteria for the service so none of the participants will have received a diagnosis at any point. Participants were at various stages of the Tier 3 weight management programme, which is a 14-week, largely psychological intervention based on cognitive behavioural therapy. The programme makes no mention of FA at any point.

All six participants were female (not by design; only females responded to the leaflets), and the ages ranged between 32 and 64 years. All were obese and believed themselves to be addicted to food, and all had been put forward for bariatric surgery; four had put themselves forward and two had been put forward by their GP.

## 2.2. Interviews

Following ethical approval from the University Psychology Research Ethics Committee, participants were briefed and provided signed consent before data were collected via semi-structured, one-on-one interviews with each participant that took place in quiet rooms with only the interviewer and the participant present. The interviews were recorded on a Dictaphone, personal information including names were removed from the data set and participants were fully debriefed at the end of each interview.

## 2.3. Analytic Process

Interviews were individually transcribed and systematically analysed. The first stage in the IPA process was the reading and re-reading of the transcript. The next stage was the notation of the transcript. This was a free textual analysis done so that anything of interest is noted. The next stage was the development of the themes. Once all the notations had been converted into themes, they were examined for connections between them. They were grouped according to similarity, and super-ordinate themes were created. This was carried out in two ways: either a new name was created for a cluster of themes; or one of the themes within a group was given the status of super-ordinate theme. A table of super-ordinate and sub-themes was then created, before repeating the process with the other transcripts. Once all the transcripts were analysed, patterns were identified across cases. A table was created with quotations from the original transcripts illustrating the relationships between themes and data.

## 3. Results

Analysis revealed four main themes: I breathe food, Isolation, Identity and Diagnosis and treatment. Table 1 provides an overview and discussion follows using quotations from the transcripts to illustrate the analytical arguments for these themes.

*Table 1. Master Themes and related Superordinate Themes.*

Master Theme	Superordinate Themes
I breathe food	I've got to have food in the house but if it's there I will eat it Just a click of the fingers It's always there Why do I eat...? As soon as I have some, that's it Being fat
Isolation	A food centric world Isolation It's a joke The real me
Identity	Less than human When I look in the mirror I can't see myself as big as I am Diagnosis: a starting point
Diagnosis and treatment	Being noticed No treatment Hope

### 3.1. Breathe Food

This theme represents a constant need for proximity to food and the discomfort this proximity engendered, the way cravings can appear as if from nowhere and the obsession with food. It also encapsulates what food gives to participants; what drives their eating, and why it become out control once it has begun.

The proximity to food was something that participants reported needing, Leanne said:

*You could class that as an addiction because you are*

*waiting for your next cigarette, you are waiting for your next drink or you've always got to have something near you, you've always got to know there's drink in the house. Or, you know, you've got to know there's a pack of cigarettes somewhere. I've gotta know there's food in the fridge.*

She believes that this need for constant access to food, almost an inability to function if it is not there, can be explained as addiction. She seems to make sense of her behaviour by comparing it to that of formally recognised addictions.

Another sub-theme 'just a click of the fingers' was most pronounced when participants described how the urges for food can hit them completely out of the blue with no

apparent trigger; and how in these situations participants have no choice but to comply with the craving. Shelly:

*You just feel like, 'Yes! Today's the day I'm gonna start, I'm gonna do it', and I have done it before; I have been able to leave it... You feel SO good and you believe you can do it right up to the last minute and then something changes [CLICKS FINGERS] and it's like 'chocolate bar' and you go and eat it.*

She describes a dramatic shift in thinking patterns, from believing she has overcome her addiction to giving in to it at a click of the fingers.

Participants also spoke of how they constantly think about food. Sue makes sense of this obsession around food by comparing her thought to that of someone who is not addicted to food. Sue:

*Not waking up thinking about it, not going to bed thinking about it. Not, sort of, buying certain magazines from the shelves and the pictures on the front because there's a nice roast or chicken dinner or cake or dessert or... I just visualise myself eating them where somebody that is just overeating...*

Sue paints the picture of herself as almost in a trance-like state, with food as a constant and intrusive obsession. She thinks that this obsessional thinking about food is a defining feature of her addiction and something that sets her apart from non-addicts. Her use of the phrase '*I breathe in food*' conveys that, like oxygen, food is something that is essential to her survival, that she has no choice but to constantly seek it out.

### 3.2. Isolation

Being isolated as a result of uncontrolled eating was a theme that emerged across all interviews. This included the real or imagined judgement felt from those who are not reliant on food, the solitude resulting from the shame surrounding their behaviour and its consequences, and that FA is seen as something of a joke.

All participants talked of the stigma attached to being overweight. This ranges from the real or imagined judgements they face from members of the public to their own judgements of other overweight people. Sue talks about how when she is out food shopping and sees someone looking in her trolley:

*When you're out and about, I feel everyone's looking at you because you're a larger person; I think, 'They're judging you' – 'Oh, what's that fat cow doing having that? She doesn't need that' [or] 'Oh, no wonder she's fat, look what she's got in her trolley'.*

Leanne had to face the reality that her husband is less attracted to her because of her weight and although she says they got past it, her use of the phrase 'blah blah blah' indicates that she wants to skim over the details because she still finds it painful. Her admission that it is, in fact, still an issue intimates that, rather than dealing with it, they simply pushed it to one side, but it remains a source of discomfort:

*When I first met my second husband he had an issue, ah*

*no. I met him, obviously, started going out, blah blah blah, he had an issue, um, with, um, sex – didn't wanna do it because it put him off. And I said, 'Is it my weight?' and he said, 'Yeah, I do have a bit of an issue'. We got over that, okay. We got over that, got married, blah blah blah blah um, I know it's still an issue deep down inside; I know it is still an issue with him.*

Participants find that their out of control eating and its consequences have driven them to be solitary and secretive people who do not enjoy being in the company of others and often hide their behaviour from those around them. For her part, Sue talks about the lengths she goes to in order to hide her eating from her partner:

*Yeah, I don't know, it's hard to, even talking about it now I'm thinking, like 'oh, what can I find when I get out of here, maybe something to eat in the car when I'm going back' and then it's where I can dispose of the rubbish so I'm not, sort of, caught out.*

The way she talks about this sounds as if Sue is in her own world with food, scheming and plotting so that she is not discovered.

'It's a joke' illustrated how participants felt that society does not view FA as a serious condition. Making jokes also surfaced when the participants themselves used it as a way of dealing with others when discussing their addiction and its consequences. Sue told her doctor that she believed she was addicted to food:

*I said... that I had an addiction to food, but nobody ever recognised it and thought it was serious. They just laugh at you and poo-poo the, sort of, answer, really. But if you've got drug abuse or [are] an alcoholic, smoking, [there] always seems to be help more readily available out there.*

To have it dismissed in this way made her feel even more alone with her condition and perhaps prevented Sue from seeking help thereafter. Nevertheless, having used drugs and alcohol as a comparison, she thinks disclosure about FA should be taken just as seriously.

### 3.3. Identity

Identity is a theme present across all the interviews and included how eating had impacted on participants' true selves. How participants viewed themselves as being almost sub-human in comparison with their peers and how they have a level of denial regarding the impact their food intake has had on their size.

Participants made sense of some of the less desirable aspects of their eating and behaviour such as secret eating and becoming withdrawn from social events, which conflicts with their usual life values, by attributing them to a side of them other than the 'real' them. Others seemed to have accepted these traits and explain them by ascribing them to a rebellious part of their personality that they are unsure about letting go. Naomi describes negative characteristics she gained as a result of the desire to eat, that cause her distress:

*No one's gonna know that's gone, so I had it. And then I got the box, put it in a bag, put it in the dustbin and no one*

*even knows. They've not even seen it. My husband's not even lifted the lid of the dustbin and thought, 'Who's had that Easter egg?' 'Cos I've put it in a bag to hide it. So, it's like crafty; it makes you crafty.'*

Here, she not only feels that she has lost part of herself, but that she has gained an identity that she neither recognises nor wants.

Feeling less than human manifested itself either through participants comparing themselves to animals, by making a distinction between themselves and normal people or through a desire to disappear. Sue explains this:

*Um, sometimes I feel a pig. If you're at a party or a buffet, I'm the person who will keep sneaking up and sneaking up because it seems such a waste for all this food, and there's me, who loves it so much.*

This paints a picture of Sue as an animal sneaking around amongst humans, unable to control herself or behave like everyone else. This really evokes an image of the participants as people whose desire for food renders them undignified and unable to behave as other humans around food.

### 3.4. Diagnosis and Treatment

Diagnosis and treatment was as an overarching theme and included the belief that being given a diagnosis of addiction would not only lead to treatment but would also result in "food addicts" being accepted by health professionals, the general population and themselves. However, another sub-theme was the doubt in the existence of an effective treatment other than forced separation from food or surgical alterations that would mean overeating was impossible. Related to this was the sub-theme of hope in terms of finding a new and perhaps magic cure for their overeating, while this was within the context of the participants having tried all the available solutions already.

The idea of diagnosis being a starting point for treatment emerged. Janine describes her treatment journey for both hyperthyroidism in terms of a comparison:

*Yeah, so that was one thing that once I was diagnosed I got help. Um, I could make decisions about alternative answers to it. I could take the medication, I could have an operation...*

Her description shows her views on the normative process for dealing with health conditions and her desire for her eating problems to be dealt with in the same way. It also, somewhat simplistically, reveals her belief that a diagnosis will automatically lead to a variety of treatment options. Overall then, there seems to be a common belief that diagnosis is an essential part of the treatment process and that the absence of it within the current status quo is denying individuals with food addiction the necessary support.

An indicator that suggests the participants do not believe in a successful treatment was the use of the word 'hope' regarding future success. When talking about individuals who are unsuccessful after bariatric surgery, Naomi explained:

*Well, that's what I hope, that would be, that would be my... my hope that that would happen. I mean, you do hear of people that have liquidised Mars bars and, I mean, you do*

*hear all that. So... I hope that that wouldn't happen to me, but who knows?*

## 4. Discussion

The current study explored the experiences of obese individuals who believe that they are addicted to food. Participants described their need to have food at hand, and the sense of panic they experienced when they did not have access to it. This sometimes led them to abandon activities such as social gatherings in order to obtain food, something that conflicted with their usual values, which they could only make sense of in terms of an addiction. This type of behaviour is reminiscent of behaviours in drug users [18]. The desperation participants felt seems to be in response to a pre-empted fear of experiencing a craving, which they describe as coming on 'at a click of the fingers'. The anxiety felt by the participants at the thought of 'not having enough' food indicates that these cravings are very unpleasant and to be avoided at all costs. This finding is similar to the results of a qualitative study carried out by Malika *et al.* [19], in which the participants reported that food addicts need to have access to food at all times, and that they are prepared to take socially undesirable actions in order to acquire food. That they would engage in these (often anti-social) behaviours had to have a compelling explanation for participants, and they could only make sense of this in terms of an addiction.

When participants described their strongest cravings, they often mentioned that these are preceded by a period of restraint from food. This is notable, in that it has been suggested that intermittent access to food, rather than any neurochemical effects, produces addiction-like behaviours such as craving and uncontrolled eating [20].

Another feature that emerged from this study was obsessional thinking about food, such as planning meals, reviewing what had been consumed earlier that day, and looking at food magazines. These descriptions resemble those of substance use [18], spending significant amounts of time obtaining, using, and recovering from the effects of a substance. The equivalent criterion for gambling disorders states that the sufferer 'is often preoccupied with gambling (e. g. having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble)' [18], which is similar to what is described in the current study. This offers evidence supporting the notion that, should a disorder for addictive food consumption be created, a behavioural 'eating addiction' may better describe it [21].

A theme that is also in line with other addictions is 'Isolation', where participants described how difficult they found living in a food-centric world. This relates to what [22] term the 'obesogenic environment'. Aspects of the environment that encourage weight gain have been found to include access to calorie-dense food, exposure to food advertisements, and decreasing opportunities to be physically active [23]. Although it has been found that some individuals are more disposed to react to food imagery than others [24],

research into whether this translates into overeating has produced mixed results [2]. In the present study, participants believed that they are more susceptible to the impact of an obesogenic environment than others and attribute this to being addicted to food. If their eating is mainly triggered by habits and responses to food-related cues, then it would be logical to conclude that constant exposure to food and food advertising would exacerbate their uncontrolled eating; however, their belief that this is down to the addiction seems to mean that they have less faith in their ability to resist the food cues they come across day to day.

Stigma appears to be unique to those who believe themselves addicted to food, rather than to all obese individuals. It has been suggested that labelling 'uncontrolled eating' an 'addiction' may increase the stigmatisation of obese individuals, and that it would shift focus away from public policy change and back onto individual behaviour modification treatments, which are often ineffective [25]. However, data from our study points to the lack of classification as a source of stigma, even in healthcare settings. Being treated with dignity and respect has been found to be associated with improved healthcare outcomes [26] and is stipulated by the care and social act regulations [27]. Having serious concerns dismissed by healthcare professionals (as the participants in this study discussed) may be detrimental to the future treatment-seeking and health outcomes of individuals who believe they have FA.

Participants in this study identified secret eating as evidence of addiction and something that causes distress in the form of shame, guilt, and feelings of a loss of identity. Recent studies into laypeople's understanding of FA have not found secret eating to be a significant feature [15, 19]; however, these studies either did not include self-perceived food addicts or used samples of the general population who were not obese. Body-related shame has been linked to secret eating in young people [28], so it is conceivable that in the current study, secret eating is the result of shame regarding obesity combined with a strong desire to eat.

Another theme that emerged during the analytical process of this study was the effect that addiction has on perceived identity, in that participants attempted to distance themselves from their addictive behaviour by creating multiple selves, stipulating that the food addict was not the 'real' them. Interestingly, qualitative research on drug and alcohol addiction has repeatedly found the theme of 'the self' appearing under different guises [29]. The present study also found evidence of internalisation of the weight bias they have experienced from others by describing themselves in sub-human terms and referring to themselves as 'pigs'. This was not just in connection with weight, but also binge eating or inability to stop snacking. Internalisation of weight bias is when individuals allow the external prejudice they have experienced to impact their self-evaluation related to their weight, character, and the extent to which they deserve respect from others [30], and has been associated with reduced self-esteem and decreased motivation to lose weight in obese individuals [31].

Furthermore, this study was the first of its kind to explore in depth what treatment options self-perceived food addicts believe should be made available. Participants in this study stated that getting a diagnosis of FA is an essential part of the process of overcoming their 'problem'. When discussing the treatment options that should be made available, participants touched on a lack of self-efficacy. The only solution they could envisage was one in which all control was taken from them, such as being locked away from food. This belief of feeling unable to control food intake may appear fatalistic; however, it is logical given that abstinence is the recommended course of treatment for those with severe substance or alcohol use disorders [32]. Many alcoholics believe that they will never be able to drink moderately [33], and therefore it is not unreasonable for self-perceived food addicts to have similar expectations of their future control over eating. There is evidence to suggest that individuals with alcohol problems can return to moderate drinking [34], but crucially, a belief in one's ability to moderate one's alcohol consumption (i. e. self-efficacy) is a strong predictor in eventual alcohol moderation [35]. This has implications for clinicians working with self-perceived food addicts, in that abstinence is not possible with food, so working to increase self-efficacy with regards to controlled eating would be vital to the recovery process.

The perceived lack of treatment options available to them has led many of the participants to pursue commercial and alternative routes in an attempt to 'cure' their addiction; their intense desire to change appears to make them vulnerable to claims that, as they themselves admit, seem fantastical. This is a concern that should be considered when dealing with patients with self-perceived FA, because the desire for a 'magic bullet' treatment for obesity has been found to cause individuals to seek out potentially dangerous, unregulated treatment options [36].

The participants in this study were all on the pathway towards bariatric surgery, and this came up as another treatment option about which they were sceptical, hoping rather than believing that it would be the most suitable intervention for them. Bariatric surgery costs between £6,000 and £15,000 per procedure, has long-term implications for those who elect to undergo it and, to be successful, requires patients to follow a strict eating plan both before and after the operation [37]. It should not, therefore, be entered into if the patient is not fully committed to the procedure, although such a lack of commitment was indicated by some patients in this study. In addition, it has been found that loss of control when eating [38] and disordered eating patterns such as grazing [39] are predictors of poorer outcomes for bariatric surgery; therefore, individuals such as the current participants may not be the best candidates for this treatment option.

As with all studies using an IPA design, the present findings are intended as exploratory, and should be applied to the wider population only tentatively. This group are distinct, all having a BMI of over 35 and obesity-related health comorbidities, and all being on the bariatric surgery pathway. Some of these factors need to be taken into consideration

when interpreting the results and conclusions drawn from this study. When interpreting the results, attempts were made to distinguish between the effects of what the participants described as their addiction to food and those of obesity, but they are so closely related, that this was not always possible. It could even be argued that this should not have been done; when looking at the impact of alcohol use, one does not separate the longer-term impacts on health – for example, liver disease – from other effects such as missing work due to intoxication. However, this study was never intended to make assumptions about the wider obese population and does not propose self-perceived FA as a leading driver of the obesity epidemic, but rather as a problem for a sub-type of pre-disposed individuals. Another critique pertaining to the sampling is that all participants were female. This was not by design, but because no male participants came forward. This may call into question whether women are more likely to perceive themselves as addicted to food. However, other larger scale studies, for example that of Meadows *et al.* [10] have not found any differences in rates of self-perceived FA between men and women. Nevertheless, the experiences of men who perceived themselves to be food addicts should be investigated in the future as they may be different to those of women.

## 5. Conclusion

In conclusion, this study describes uncontrolled eating as an addiction to food that is experienced as obsessive thinking about food, an inability to resist food cues, an inability to control how much food is consumed and dishonesty and secrecy regarding eating. Unlike other studies that have looked at eating and obesity [4], the most pronounced trigger for wanting food was not emotional but described as a constant need to eat in the absence of any obvious trigger. This was linked to the belief that it is an addiction. Participants reported experiencing stigma due to their weight in line with other similar studies [40], however, they also revealed that the belief that they were experiencing an addiction was a source of stigma in itself in that others, including healthcare professionals, have dismissed and even ridiculed this belief. This has posed a barrier to seeking support for uncontrolled eating. Explaining behaviour as an addiction appears to also be a strategy the participants use to distance themselves from the stigma they experience. By dividing obese people into those who choose to eat too much and those with a medical explanation (in their case addiction), they absolved themselves from any blame for their weight. Participants felt that a diagnosis would be essential in order for them to receive the treatment but could not identify any possible treatments that may enable them to moderate their food intake. Much of the uncontrolled eating described in this study is comparable to behaviours seen in drug users, while some more closely resembled classification criteria for behavioural addictions. Whether FA is classified as a disorder in the future, self-perceived FA should certainly be acknowledged by healthcare professionals because

evidence from this study shows that it plays a role in the way individuals with obesity interpret their uncontrolled eating, their belief in their ability to change these behaviours and therefore the likelihood that they will engage with health services. It also provides further support of the idea that the current recommendations for obesity services, which recommend nutrition and physical activity education combined with basic behaviour-change strategies, may be woefully inadequate for people experiencing the complex relationship with food and eating described in this study.

## Author Statements

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