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Emotional Eating as a Psychological and Behavioural Problem: Mechanisms and Interventions

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Abstract

Emotional eating refers to eating that is prompted or intensified by emotional states rather than by physiological hunger alone. It is not, by itself, a psychiatric diagnosis, nor is it reducible to poor discipline or lack of willpower. Rather, it is a psychologically meaningful behavioural pattern shaped by emotion regulation, stress, coping, cognitive control, reward learning, restraint, interoception, and social context. This integrative narrative review examines emotional eating as a psychological and behavioural problem and evaluates major psychological interventions used to address it. The reviewed literature indicates that negative emotions do not uniformly increase food intake; some individuals eat more, others eat less, and effects differ across discrete emotions, contexts, and individual vulnerabilities. Emotional eating appears most clinically relevant when food becomes a repeated strategy for down-regulating distress, avoiding aversive self-awareness, obtaining immediate reward, or coping

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with stress in the absence of more adaptive alternatives. Evidence from experimental, ecological momentary assessment, observational, and intervention studies supports cognitive-behavioural, mindfulness-based, acceptance-based, and behavioural self-regulation approaches, although intervention effects vary and long-term maintenance remains uncertain. Effective practice requires individualized assessment of emotional triggers, eating functions, coping patterns, restraint, reward sensitivity, and comorbid psychological difficulties where present. The review concludes that emotional eating is best understood as a learned and context-sensitive pattern of emotion-linked eating that may be modified through non-stigmatizing, culturally responsive psychological interventions targeting emotion regulation, cognitive flexibility, distress tolerance, self-monitoring, values, and adaptive coping.

Keywords: emotional eating, emotion regulation, psychological intervention, coping, mindfulness, cognitive-behavioural therapy

Introduction/Background to the Study

Eating is a biological necessity, but human eating behaviour is not governed by physiology alone. Hunger, satiety, metabolic need, and food availability are central determinants of food intake; however, eating is also shaped by emotions, habits, memories, interpersonal contexts, social norms, food reward, cultural meanings, and environmental cues. In everyday life, people may eat because they are hungry, because food is available, because others are eating, because eating is pleasurable, or because food provides comfort during emotional discomfort. This intersection between affect and eating behaviour has made emotional eating an important topic in clinical, health, and eating psychology.

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Emotional eating is commonly defined as the tendency to eat in response to emotional states rather than physiological hunger, particularly during negative affect such as sadness, anxiety, anger, loneliness, boredom, shame, or stress (Smith et al., 2023). Recent reviews have refined this definition by emphasizing that emotional eating under negative affect involves eating responses during unpleasant emotional states that are not adequately explained by hunger alone (Fu et al., 2026). This distinction is important because emotional eating does not necessarily involve large quantities of food, loss of control, obesity, or a formal eating-disorder diagnosis. It is a behavioural pattern whose significance depends on frequency, function, distress, impairment, health consequences, and the individual's broader psychological context.

The topic is clinically relevant because emotional eating may become self-reinforcing. A person may experience distress, eat highly palatable food, obtain temporary distraction or relief, and subsequently learn that eating is an accessible method of regulating affect. If relief follows eating, the behaviour may be negatively reinforced: eating becomes more likely during future distress because it temporarily reduces unpleasant emotion. In some cases, the person may later experience guilt, self-criticism, dissatisfaction, or concern about eating behaviour, which can generate further distress and maintain the cycle. This pattern does not imply moral weakness; rather, it reflects learned associations among emotion, cognition, reward, coping, and behaviour.

The empirical literature also cautions against a simplistic claim that negative emotion automatically produces overeating. Macht's (2008) five-way model proposes that emotions influence eating through multiple pathways: they may increase intake, suppress appetite, alter

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food choice, impair cognitive control, or lead individuals to eat for emotion regulation. Experimental evidence similarly indicates that the effects of emotion on eating vary across individuals, emotional states, and study methods (Evers et al., 2018). Ecological momentary assessment (EMA) research has further shown that real-time links among stress, emotion, hunger, taste-driven eating, and body mass index (BMI) are moderated by emotional-eating style and individual differences (Reichenberger et al., 2018).

Therefore, emotional eating is best conceptualized as a heterogeneous psychological and behavioural phenomenon. It may be adaptive or relatively harmless when occasional eating provides comfort, pleasure, or social connection without distress or impairment. It becomes clinically significant when eating is repeatedly used as the dominant strategy for managing distress, when it undermines valued goals, when it contributes to loss of control or shame, or when it co-occurs with broader mental-health or eating-related difficulties. This review examines the mechanisms and interventions relevant to emotional eating while avoiding stigmatizing assumptions about body size, food choice, or personal discipline.

Statement of the Problem

Emotional eating is often misunderstood in both public and clinical discourse. Popular explanations may frame it as weakness, indiscipline, greed, or simple failure of dietary control. Such interpretations are psychologically inadequate and may increase shame, which itself can become a trigger for further maladaptive eating. Conversely, some descriptions overpathologize emotional eating by treating it as equivalent to binge-eating disorder or obesity. These extremes obscure the complexity of the phenomenon.

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The problem is threefold. First, emotional eating is conceptually heterogeneous. Studies use varying definitions, measures, samples, and outcomes, making it difficult to determine whether they are assessing the same construct (Braden et al., 2025; Smith et al., 2023). Second, the mechanisms linking emotion and eating are complex. Negative affect, stress, coping style, emotion-regulation difficulties, reward sensitivity, restraint, cognitive control, interoceptive awareness, and social context may all influence emotional eating, but not in the same way for every individual (Altheimer & Urry, 2019; Hooper & Lim, 2023; Macht, 2008). Third, intervention evidence is promising but heterogeneous. Cognitive-behavioural, mindfulness-based, acceptance-based, behavioural weight-management, and broader self-regulation interventions can reduce emotional eating, yet effect sizes, mechanisms, target populations, and durability of change vary (Chew et al., 2022; Power et al., 2025; Smith et al., 2023).

A psychologically rigorous review is therefore needed to clarify emotional eating as a behavioural pattern rather than a moral failing or automatic disorder, integrate the main theoretical explanations, summarize empirical evidence, and identify intervention principles relevant to psychological practice.

Purpose of the Study

The purpose of this integrative narrative review is to examine emotional eating as a psychological and behavioural problem and to synthesize evidence on mechanisms and psychological interventions. Specifically, the review aims to:

1. Clarify the meaning of emotional eating and distinguish it from binge-

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eating disorder, ordinary eating for pleasure, and eating in response to positive emotion.

2. Examine theoretical explanations of emotional eating, including emotion-regulation models, Macht's five-way model, escape theory, coping and negative reinforcement, restraint and cognitive-control perspectives, reward and decision-making approaches, and individual-difference frameworks.

3. Review empirical evidence on emotional eating in relation to negative affect, discrete emotions, stress, coping, reward, interoception, social context, body weight, measurement, and heterogeneity.

4. Evaluate psychological interventions, including cognitive-behavioural therapy (CBT), mindfulness and mindful eating, acceptance and commitment therapy (ACT) or acceptance-based approaches, behavioural self-regulation, values-based work, goal setting, and feedback.

5. Identify implications, limitations, and recommendations for culturally responsive, non-stigmatizing psychological assessment and intervention.

Literature Review

Theoretical Framework

Conceptual Definition of Emotional Eating

Emotional eating refers to eating that occurs in response to emotional experiences rather than physiological hunger alone. Although the term is frequently associated with negative affect, emotions may influence eating in diverse ways. Negative emotions may increase eating in some people, reduce appetite in others, or change food choice without

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substantially increasing total intake (Fu et al., 2026; Hooper & Lim, 2023; Macht, 2008). Positive emotions may also influence eating, especially in social, celebratory, or reward-based contexts. Therefore, emotional eating should not be reduced to "eating when sad" or "overeating when stressed."

A more precise definition recognizes emotional eating as an emotion-linked behavioural response that may involve increased intake, altered food choice, eating in the absence of hunger, craving for palatable food, or reliance on food for comfort, distraction, or reward. It becomes psychologically problematic when it is frequent, distressing, difficult to regulate, incompatible with valued goals, or associated with broader impairment.

Macht's Five-Way Model of Emotion and Eating

Macht's (2008) five-way model provides a foundational framework for understanding the diverse effects of emotion on eating. The model proposes that emotions may influence eating through at least five pathways. First, emotions produced by food itself may shape food preference and consumption. Second, high-intensity emotions may suppress eating by disrupting appetite. Third, moderate emotional arousal may alter food choice and meal patterns. Fourth, emotions may impair cognitive control over eating, particularly among restrained eaters. Fifth, some individuals may eat in order to regulate emotional states.

This model is important because it rejects a single-mechanism explanation. Emotional eating may involve appetite, reward, cognition, learned coping, restraint, and regulation. For example, anxiety may suppress intake in one individual but increase intake of sweet or highly palatable foods in another. Anger, sadness, loneliness, boredom, shame, and stress may also have different effects depending on personal history, social context, and available coping

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resources. Macht's model therefore supports a nuanced clinical approach in which the psychologist asks not only whether emotion precedes eating, but what kind of emotion, in what context, for what function, and with what consequence.

Gross's Process Model of Emotion Regulation

Emotion regulation refers to the processes through which individuals influence which emotions they have, when they have them, and how they experience or express them (Gross, 1998b). Gross's process model distinguishes between antecedent-focused strategies, such as situation selection, situation modification, attentional deployment, and cognitive reappraisal, and response-focused strategies, such as expressive suppression (Gross, 1998a, 1998b). Reappraisal involves changing the meaning of a situation before emotional responses become fully developed, whereas suppression involves inhibiting emotional expression after the emotion has already occurred.

This distinction is relevant to emotional eating because eating may function as a response-focused regulatory strategy. Rather than modifying the emotional trigger or reappraising the meaning of an event, the person may attempt to reduce distress after it has emerged by consuming food. Such eating may provide sensory pleasure, distraction, physiological soothing, or temporary escape. However, if it becomes the primary regulatory method, the person may have fewer opportunities to develop antecedent-focused strategies such as problem-solving, boundary setting, reappraisal, social support seeking, or planned coping.

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Difficulties in Emotion Regulation

Emotion-regulation difficulties provide a further theoretical explanation. Gratz and Roemer (2004) conceptualized emotion dysregulation as a multidimensional construct involving limited emotional awareness, lack of emotional clarity, nonacceptance of emotional responses, impulse-control difficulties under distress, limited access to effective regulation strategies, and difficulty engaging in goal-directed behaviour when upset. Emotional eating may be especially likely when individuals experience distress as intolerable, have difficulty identifying what they feel, or struggle to pursue valued goals during emotional arousal.

From this perspective, emotional eating is not merely a response to emotion; it may be a response to difficulties managing emotion. A person who cannot clearly identify whether they are lonely, overwhelmed, ashamed, bored, or angry may experience the emotion globally as discomfort and respond with an immediately available soothing behaviour. Food, especially highly palatable food, can then become a rapid but incomplete regulatory tool.

Negative Reinforcement, Coping, and Learning

Learning theory and coping models help explain the maintenance of emotional eating. If eating reduces distress, distracts attention, or produces comfort, the behaviour is negatively reinforced because the removal or reduction of unpleasant affect increases the likelihood of future eating in similar emotional states. Evers et al. (2010) similarly describe emotional eating as a possible emotion-regulation strategy through which food provides immediate relief or affective change. Eating may also be positively reinforced through taste, pleasure, reward, and social meaning.

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Spoor et al. (2007) found that emotion-oriented coping and avoidance distraction were related to emotional eating, even after controlling for negative affect, in both eating-disordered and community women. This suggests that how individuals cope with distress may be as important as the distress itself. Eating may become an avoidance-based coping strategy when it shifts attention away from emotional pain, interpersonal conflict, self-criticism, or environmental stressors. However, avoidance does not resolve the underlying problem, and repeated reliance on food may reduce the development of more flexible coping skills.

Escape Theory as a Qualified Bridge

Heatherton and Baumeister's (1991) escape theory was developed to explain binge eating as an attempt to escape from aversive self-awareness. According to this model, individuals may narrow attention to immediate stimuli and reduce higher-order self-evaluation in order to escape painful self-awareness, which can weaken inhibition and increase disinhibited eating. This theory should not be used to equate emotional eating with binge-eating disorder. Binge eating involves specific features such as consuming an objectively large amount of food with a sense of loss of control, whereas emotional eating may occur without these features.

Nevertheless, escape theory provides a useful bridge for understanding some emotional-eating episodes. In certain cases, eating may help the person avoid self-critical thoughts, shame, perceived failure, or overwhelming self-evaluation. The mechanism is not necessarily hunger, but narrowed attention and temporary relief from self-awareness. This theoretical link is useful only when applied carefully and individually; many instances of emotional eating are not binge episodes and should not be pathologized as such.

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Restraint and Cognitive-Control Perspectives

Cognitive restraint refers to deliberate restriction or regulation of food intake, often through dietary rules. Restraint may interact with emotion in complex ways. Individuals who rigidly restrict eating may be more vulnerable to disinhibition when distressed or when they perceive that a dietary rule has been broken. Negative thoughts such as “I have failed” or “I have ruined my diet” may intensify distress and contribute to further eating. Macht’s (2008) model identifies impairment of cognitive eating control as one pathway through which emotions influence intake.

Experimental evidence supports the moderating role of restrained eating. Evers et al. (2018) reported that effects of emotion on eating vary substantially and that negative emotion appears more likely to increase eating among restrained eaters. This suggests that emotional eating is not a simple direct consequence of negative affect. Rather, it may emerge from the interaction of affective arousal, dietary restraint, self-control depletion, rigid rules, food availability, and learned expectations about food and mood.

Reward, Decision-Making, and Food Choice

Food reward is central to emotional eating. Highly palatable foods can provide immediate sensory pleasure and may become associated with relief, comfort, or reward. Hooper and Lim (2023) emphasized that emotion can alter eating decisions through reward sensitivity, hedonic motivation, interoception, social isolation, stress, and decision-making processes. Fu et al. (2026) similarly argued that negative affect can bias food choice toward immediate rewards, even when total intake does not uniformly increase.

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This reward-based perspective is useful because emotional eating may involve changes in what is eaten as much as how much is eaten. Under distress, an individual may not necessarily consume more calories overall but may show increased preference for sweet, salty, fatty, or otherwise highly palatable foods. Negative affect may shift decision-making toward short-term relief and away from long-term goals. Intervention therefore needs to address reward learning, craving, delay of gratification, values-based choice, and alternative sources of reinforcement rather than relying solely on nutritional advice.

Ecological Momentary Assessment and Individual Differences

Ecological momentary assessment provides an important corrective to retrospective self-report. EMA studies assess emotions, cravings, stress, hunger, and eating close to real time in natural environments, reducing recall bias. Reichenberger et al. (2018), using 10 days of EMA, found that emotional-eating style moderated associations between negative emotions and taste- and hunger-based eating, and that BMI also moderated some associations. Their findings support the view that emotion-eating links differ across individuals and contexts.

Altheimer and Urry (2019) also highlighted the importance of previous experiences and social context. Emotions do not influence eating in isolation; their effects depend on learning history, food availability, interpersonal environment, cultural meanings, and expectations. A lonely person eating at night, a student snacking during examination stress, and a family eating during celebration may all be responding to emotion, but the psychological meaning and clinical relevance differ.

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Distinguishing Emotional Eating From Related Phenomena

Emotional Eating and Binge-Eating Disorder

Emotional eating is not synonymous with binge-eating disorder. Emotional eating describes a pattern in which emotional states influence eating. Binge-eating disorder is a formal psychiatric diagnosis requiring recurrent binge-eating episodes characterized by eating an objectively large amount of food with a sense of loss of control, accompanied by associated features and distress. Emotional eating may occur in individuals with binge-eating disorder, but it may also occur in people who do not meet criteria for any eating disorder (Smith et al., 2023).

This distinction matters clinically. Treating all emotional eating as binge-eating disorder may overpathologize common behaviour and increase shame. Conversely, ignoring loss of control, marked distress, compensatory behaviours, or significant impairment may delay appropriate referral and treatment. Psychological assessment should therefore examine frequency, quantity, loss of control, distress, impairment, compensatory behaviours, body image concerns, mood symptoms, and medical risk where relevant.

Emotional Eating and Eating in Response to Positive Emotion

Not all emotion-linked eating is problematic. People often eat during celebrations, rituals, family gatherings, religious events, and social bonding. Positive emotions may increase eating through pleasure, reward, and social facilitation. Such eating may be psychologically healthy when it supports connection, meaning, and enjoyment without distress or impairment. The clinical concern arises when eating is experienced as uncontrollable, used rigidly as the primary emotional coping strategy, or followed by

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significant shame, distress, or harm.

Emotional Eating and Ordinary Appetite Variation

Appetite naturally fluctuates with sleep, stress, physical activity, menstrual cycle, illness, food availability, medication, and daily routine. Emotional eating should therefore not be inferred from a single episode of eating in the absence of strong hunger. The relevant question is whether there is a repeated pattern in which emotional states predict eating in a way that causes distress, undermines self-regulation, or serves as avoidance of emotional needs.

Empirical Review

Heterogeneity of Emotion-Eating Associations

A consistent finding across the literature is heterogeneity. Negative emotion does not produce the same eating response in all people. Macht (2008) emphasized that intense emotions may suppress appetite, whereas moderate negative emotions may increase eating among those who have learned to regulate affect through food. Evers et al. (2018), in a meta-analysis of experimental evidence, found that emotion effects on consumption varied by participant characteristics and methodological factors, with restrained and emotional eaters showing particular vulnerability under some conditions.

This heterogeneity has important implications. First, emotional eating cannot be assumed from the presence of stress or sadness alone. Second, intervention should not be standardized only around reducing food intake. Some individuals may need skills for distress tolerance; others may need flexible restraint, improved interoceptive awareness, social

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support, treatment for depression or anxiety, or alternative reward sources.

Discrete Emotions and Stress

Research increasingly recognizes that "negative affect" is too broad. Sadness, anxiety, anger, boredom, loneliness, shame, and stress may influence eating differently. Hooper and Lim (2023) argued that discrete emotions can affect eating decisions through different pathways, including reward valuation, interoceptive signals, and social context. Fu et al. (2026) similarly emphasized that negative affect may influence food choice and eating pattern even when the effect on total intake is inconsistent.

Stress is one of the most studied emotional triggers. Stress may increase desire for immediate reward, narrow attention, reduce planning, and intensify cravings. However, stress may also suppress appetite, particularly when acute or intense. The direction of effect depends on the person, the stressor, the available foods, learned coping patterns, and physiological state. Therefore, stress-related emotional eating should be understood as a probabilistic, not deterministic, process.

Coping Style and Avoidance

Coping style is strongly relevant to emotional eating. Spoor et al. (2007) showed that emotion-oriented coping and avoidance distraction were associated with emotional eating, suggesting that the way people respond to distress contributes to eating behaviour beyond the mere presence of negative affect. This supports clinical models in which emotional eating is maintained by avoidance, distraction, and temporary relief.

CBT and acceptance-based approaches both draw on this insight. CBT helps

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individuals identify antecedents, thoughts, feelings, and consequences, while acceptance-based work helps individuals experience distress without automatically avoiding it through eating. The empirical link between coping and emotional eating supports interventions that teach alternative coping skills rather than focusing only on dietary rules.

Reward Sensitivity, Craving, and Decision-Making

Reward processes help explain why emotional eating often involves highly palatable foods. Such foods provide immediate sensory pleasure and may be readily available in many environments. Under distress, decision-making may shift toward immediate relief and away from longer-term goals (Fu et al., 2026; Hooper & Lim, 2023). Food may therefore become a learned reward cue associated with comfort, escape, or self-soothing.

Reward-based accounts also explain why emotional eating may persist despite negative long-term consequences. The immediate reward is certain and rapid, whereas the benefits of alternative coping strategies may be delayed. Psychological intervention must therefore help clients develop alternative sources of reinforcement, tolerate delayed reward, and reconnect eating decisions with personally meaningful values.

Interoception, Hunger, and Satiety Awareness

Interoception refers to awareness and interpretation of internal bodily signals. Emotional eating may involve difficulty distinguishing emotional arousal from hunger, craving, fatigue, or bodily tension. Hooper and Lim (2023) identified interoception as an important factor in emotion-related eating decisions. When interoceptive awareness is low, a person may misinterpret distress as hunger or respond to vague discomfort with eating.

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Mindful eating and self-monitoring may improve awareness of hunger, satiety, cravings, and emotional states, although such approaches should be applied flexibly and without encouraging obsessive monitoring.

Social Context and Environment

Emotional eating occurs in social and environmental contexts. Altheimer and Urry (2019) argued that prior experiences and social context shape whether emotions lead to eating. Social isolation, interpersonal conflict, family eating norms, cultural meanings of food, availability of palatable foods, work stress, financial strain, and exposure to food cues can all influence emotional eating. This is particularly important for culturally responsive practice. Food is not merely a biological substance; it may carry meanings of care, identity, hospitality, celebration, grief, and belonging. Interventions that ignore these meanings risk being ineffective or stigmatizing.

Emotional Eating, Obesity, and Weight Outcomes

Emotional eating is associated with weight-related outcomes in some studies, but it should not be treated as synonymous with obesity. Some individuals who emotionally eat are not in higher-weight bodies, and many higher-weight individuals do not emotionally eat. Konttinen (2020) reviewed emotional eating in relation to obesity, depression, sleep, and genetic susceptibility, emphasizing the complex interplay among psychological, behavioural, and biological factors. Braden et al. (2025) similarly identified emotion regulation and learning principles as important in emotional eating among adults with obesity, while noting construct-definition and measurement limitations.

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Intervention reviews suggest that emotional-eating interventions may produce reductions in emotional eating and modest weight-related changes among adults with overweight or obesity (Chew et al., 2022; Smith et al., 2023). However, BMI and weight should not be treated as the only clinically relevant outcomes. Distress, loss of control, coping flexibility, quality of life, metabolic health, self-compassion, and eating-related functioning may also be important.

Measurement Issues

Measurement remains a major limitation. Emotional eating is often assessed through self-report questionnaires, which may be affected by recall bias, social desirability, beliefs about one's eating, and difficulty accurately identifying emotional antecedents. EMA provides more context-sensitive information by assessing affect and eating close to the moment they occur (Reichenberger et al., 2018). However, EMA also has burdens and may not capture all relevant dimensions of eating behaviour.

Variation in measures and definitions complicates comparison across studies. Some studies define emotional eating as increased food intake under negative affect; others emphasize craving, food choice, eating in the absence of hunger, or self-reported tendency. Braden et al. (2025) identified measurement and construct-definition issues as ongoing challenges. Future research requires clearer operational definitions and multimethod assessment.

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Cognitive-Behavioural Therapy

CBT is one of the most widely used approaches for emotional eating. CBT conceptualizes emotional eating as a learned pattern maintained by antecedents, thoughts, emotions, behaviours, and consequences. Intervention may include self-monitoring, trigger identification, cognitive restructuring, problem-solving, stimulus control, relapse prevention, coping skills, and flexible planning.

In practice, CBT may help an individual identify a sequence such as: stressful event → automatic thought ("I cannot cope") → anxiety or shame → urge to eat → eating → temporary relief → guilt → renewed distress. Treatment then targets multiple points in the sequence. The person may learn to reappraise thoughts, use problem-solving, tolerate urges, plan alternative coping behaviours, and reduce all-or-nothing dietary rules.

Systematic reviews indicate that CBT-oriented approaches can reduce emotional eating, although outcomes differ across studies (Chew et al., 2022; Smith et al., 2023). CBT is particularly useful because it addresses emotional triggers, cognitive patterns, and behavioural reinforcement rather than focusing only on food restriction.

Mindfulness and Mindful Eating

Mindfulness-based interventions aim to cultivate present-moment awareness with openness and reduced automatic reactivity. In emotional eating, mindfulness may help individuals observe cravings, emotions, bodily sensations, and thoughts without immediately acting on them. Mindful eating extends this approach to hunger, satiety, taste, pace of eating,

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and awareness of internal cues.

Mindfulness may interrupt emotional eating by creating a pause between trigger and response. Instead of automatically eating when distressed, the person learns to notice: “I am anxious,” “I am craving something sweet,” or “I am seeking comfort.” This awareness can support more intentional choice. Chew et al. (2022) and Smith et al. (2023) identified mindfulness-based approaches as promising, though intervention content and effects vary.

Mindfulness should not be presented as a demand for perfect control. For some individuals, especially those with trauma histories or severe distress, inward attention may initially be uncomfortable. Therefore, mindfulness-based work should be individualized, paced, and integrated with grounding, safety, and referral where appropriate.

Acceptance-Based and ACT-Informed Approaches

Acceptance-based interventions, including ACT-informed approaches, focus on psychological flexibility: the ability to experience difficult thoughts, emotions, cravings, and bodily sensations while acting in accordance with values. This is especially relevant when emotional eating functions as experiential avoidance. The goal is not to eliminate distress or cravings but to reduce automatic, avoidance-driven behaviour.

ACT-informed work may include acceptance of emotions, cognitive defusion from thoughts such as “I must eat to cope,” values clarification, committed action, and willingness to experience urges without acting on them. Smith et al. (2023) included acceptance-based interventions among approaches used to address emotional eating. These interventions may be particularly helpful when clients are trapped in cycles of shame, rigid control, and avoidance.

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Behavioural Self-Regulation

Behavioural self-regulation approaches include self-monitoring, goal setting, feedback, problem-solving, planning, stimulus control, review of goals, and relapse prevention. These techniques are important because emotional eating often occurs automatically and habitually. Self-monitoring can help individuals identify patterns without judgment: when emotional eating happens, what emotions precede it, what foods are involved, who is present, what relief follows, and what longer-term consequences occur.

Power et al. (2025) reviewed behaviour-change techniques in emotional-eating interventions for adults living with overweight and obesity and identified techniques such as goal setting, feedback on behaviour, reviewing goals, considering pros and cons, and values- or identity-related components as potentially important. These findings support interventions that go beyond advice-giving and instead strengthen self-regulatory capacity.

Values, Meaning, and Goal Setting

Values-based goal setting is especially useful when emotional eating conflicts with broader life goals. Rather than framing intervention around weight or restriction alone, values work asks what the person wants eating and self-care to support: energy, mood stability, family participation, spiritual practice, health, mobility, confidence, or self-respect. This approach can reduce shame and increase motivation.

Goal setting should be specific, realistic, culturally appropriate, and flexible. Rigid goals may increase all-or-nothing thinking and worsen emotional eating after perceived failure. Values-based goals can support compassionate persistence and relapse prevention.

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Culturally Responsive and Non-Stigmatizing Practice

Interventions must be culturally responsive. Food practices are embedded in family, religion, ethnicity, socioeconomic realities, and community life. A recommendation that ignores food access, cultural meals, work schedules, caregiving demands, or economic constraints is unlikely to be effective. Clinicians should avoid moralizing language such as "good foods" and "bad foods" and should not assume that body size reflects discipline, health behaviour, or emotional functioning.

Non-stigmatizing practice recognizes that shame can maintain emotional eating. The therapeutic stance should emphasize curiosity, compassion, functional analysis, and skill development. Where emotional eating co-occurs with depression, anxiety, trauma, eating-disorder symptoms, medical conditions, or medication effects, practitioners should conduct appropriate assessment and refer to relevant professionals as needed.

Hypotheses and/or Research Questions

As this is an integrative narrative review and not a primary empirical study, formal statistical hypotheses were not tested. The review was guided by the following research questions:

1. How is emotional eating best conceptualized as a psychological and behavioural problem?
2. What theoretical models explain the relationship between emotion and eating behaviour?
3. What empirical evidence supports the roles of emotion regulation,

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stress, coping, restraint, reward, interoception, and social context in emotional eating?

4. How should emotional eating be distinguished from binge-eating disorder and from ordinary eating in response to positive emotion?

5. What psychological interventions have evidence for reducing emotional eating, and what mechanisms appear most relevant?

6. What are the implications, limitations, and recommendations for psychological practice and future research?

Method

Design

This article used an integrative narrative review design. It is not a new human-subject empirical study and did not involve recruitment, intervention delivery, randomization, or primary data collection. It is also not a systematic review and does not claim PRISMA compliance or a comprehensive search strategy. Instead, it synthesizes peer-reviewed theoretical, experimental, ecological momentary assessment, observational, and intervention literature identified in the supplied source base.

The review integrates foundational theories of emotion regulation, emotion-eating pathways, restraint, escape from self-awareness, coping, reward, and decision-making with empirical findings from meta-analyses, systematic reviews, EMA research, and observational studies. The aim was conceptual and critical synthesis rather than statistical aggregation.

Participants

No participants were directly recruited or assessed for the present review. The article

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discusses findings from previously published studies and reviews whose participants varied by study design, sample characteristics, age, body size, clinical status, and cultural context. Where prior reviews focused on adults living with overweight or obesity, this is noted to avoid overgeneralizing findings to all populations.

Instruments

No primary-study instruments were administered in the present review. The article discusses measurement issues in the emotional-eating literature, including reliance on self-report questionnaires and the increasing value of ecological momentary assessment. Instruments used in the original studies are not treated as instruments of the present review.

Procedure

The procedure involved conceptual selection, organization, and synthesis of literature from the supplied source base. Sources were selected because they were foundational to theory, directly relevant to emotional eating mechanisms, or informative regarding psychological interventions. The literature was organized around major themes: definition and conceptual boundaries, emotion-regulation theory, coping and negative reinforcement, restraint and cognitive control, reward and decision-making, EMA and individual differences, empirical heterogeneity, measurement, and intervention approaches.

Claims were synthesized narratively. Greater interpretive weight was given to peer-reviewed reviews, meta-analyses, experimentally informed work, EMA studies, and foundational theoretical models, while recognizing that the present review did not independently verify all possible studies in the field.

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Statistics

No statistical analyses were conducted for the present review. Effect estimates, pooled findings, or quantitative conclusions reported in this article are derived from previously published reviews and meta-analyses, not from new analysis. Because this is a narrative review, findings are interpreted qualitatively and critically rather than pooled statistically.

Discussion

The reviewed literature supports the central argument that emotional eating is a psychological and behavioural pattern maintained by emotion-regulation processes, learned reinforcement, coping style, reward, cognition, restraint, and context. It should not be dismissed as lack of willpower, nor should it automatically be pathologized as an eating disorder. Emotional eating exists on a continuum from ordinary, culturally meaningful, and occasional comfort eating to clinically significant patterns associated with distress, impaired self-regulation, loss of control, and health or psychosocial consequences.

A major conclusion is that emotion-eating links are heterogeneous. Negative affect does not universally increase eating. Some people eat less when distressed, and others change food choice rather than total intake. The effect of emotion depends on discrete emotional states, personal learning history, restraint, reward sensitivity, interoceptive awareness, stress intensity, social environment, and food availability (Altheimer & Urry, 2019; Hooper & Lim, 2023; Macht, 2008; Reichenberger et al., 2018). This heterogeneity explains why simplistic interventions based only on dietary advice may fail.

The theoretical literature converges on the importance of emotion regulation. Gross's

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process model shows that emotional responses can be regulated at different points, and emotional eating may function as a response-focused strategy after distress has already emerged (Gross, 1998a, 1998b). Gratz and Roemer's (2004) multidimensional account of emotion-regulation difficulties clarifies why some individuals may struggle to identify, tolerate, or manage affect without turning to food. Learning theory adds that short-term relief reinforces future eating under distress. Coping research further suggests that avoidance and emotion-oriented coping are relevant to emotional eating beyond negative affect itself (Spoor et al., 2007).

Reward and decision-making models strengthen the explanation. Under distress, immediate food reward may become more salient, particularly when the person lacks alternative reinforcement or experiences strong cravings (Fu et al., 2026; Hooper & Lim, 2023). The problem is therefore not simply that the person "chooses food," but that food may have become a rapid, available, and learned response to distress. Psychological intervention must help replace that function, not merely remove the behaviour.

The review also supports a careful distinction between emotional eating and binge-eating disorder. Escape theory helps explain why some eating episodes may provide temporary escape from aversive self-awareness (Heatherton & Baumeister, 1991), but emotional eating should not be equated with binge eating. This distinction protects against overdiagnosis while still encouraging appropriate clinical assessment when loss of control, distress, or impairment is present.

Intervention evidence is promising but not definitive. CBT, mindfulness, ACT-informed or acceptance-based interventions, behavioural self-regulation, goal setting,

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feedback, and values-based work can reduce emotional eating in some populations (Chew et al., 2022; Power et al., 2025; Smith et al., 2023). However, the evidence base is heterogeneous, often concentrated among adults with overweight or obesity, and limited by variation in measures and follow-up periods. The strongest clinical implication is that intervention should be individualized after functional assessment of triggers, meanings, reinforcers, and psychological needs.

Implications of the Study

This review has several implications for psychological practice, research, and health promotion.

First, assessment should move beyond food quantity and body weight. Psychologists should assess emotional triggers, antecedent thoughts, coping style, restraint, interoceptive awareness, food-related shame, reward patterns, social context, and the function eating serves. Two individuals may engage in similar eating behaviours for very different psychological reasons.

Second, emotional eating should be addressed with compassion rather than blame. Shame and self-criticism may intensify distress and increase vulnerability to further emotional eating. Non-stigmatizing language is essential, especially when working with clients in higher-weight bodies or clients with histories of dieting, trauma, or disordered eating.

Third, intervention should target emotion regulation and coping. Clients may benefit from cognitive restructuring, problem-solving, distress tolerance, mindfulness, urge surfing, behavioural activation, social support, and values-based action. The aim is not to eliminate all

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emotional eating but to increase flexibility and reduce reliance on food as the only or dominant coping strategy.

Fourth, practitioners should distinguish emotional eating from binge-eating disorder and other eating disorders. Where there is marked loss of control, recurrent binge episodes, compensatory behaviours, severe restriction, medical risk, or significant impairment, referral or specialized eating-disorder treatment may be indicated.

Fifth, culturally responsive practice is necessary. Food practices are linked with identity, family, religion, celebration, grief, hospitality, and socioeconomic realities. Effective intervention must respect these meanings and adapt recommendations to the person's context. Assessment should also consider psychosocial resources such as self-esteem and social support. In a Nigerian study of postpartum women, Onyemaechi et al. (2017) found that lower self-esteem and lower social support were associated with greater postpartum-depression symptoms. This study did not examine emotional eating and therefore cannot establish an emotional-eating mechanism; nevertheless, it supports the broader clinical principle that self-appraisal and social connectedness may be relevant contextual variables when assessing distress-related behaviour. In emotional-eating interventions, these variables should be explored without assuming that low self-esteem or limited support is present in every client.

Sixth, research should broaden outcomes beyond weight. Emotional distress, eating-related quality of life, self-regulation, shame reduction, psychological flexibility, metabolic indicators, and maintenance of change are also important.

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Limitations of the Study

This review has limitations. First, it is an integrative narrative review rather than a systematic review. It did not use a comprehensive database search, formal risk-of-bias assessment, or meta-analytic procedures. Therefore, it should be interpreted as a conceptual and critical synthesis of the supplied literature base.

Second, emotional eating is inconsistently defined across studies. Some research emphasizes eating in response to negative affect, while other work includes positive affect, cravings, food choice, or eating in the absence of hunger. This limits direct comparison.

Third, much research relies on self-report measures, which may be affected by recall bias, social desirability, limited emotional awareness, and culturally shaped interpretations of eating behaviour. EMA studies reduce some of these limitations but are not yet sufficient to resolve all measurement concerns.

Fourth, many intervention studies and reviews focus on adults living with overweight or obesity. Findings from these samples should not be generalized uncritically to children, adolescents, older adults, people in lower-weight bodies, culturally diverse populations, or individuals with diagnosed eating disorders.

Fifth, the relationship between emotional eating and weight is complex. Emotional eating may be relevant to weight change for some individuals, but weight is not the only meaningful outcome and should not be used as a proxy for psychological health.

Sixth, long-term maintenance of intervention gains remains uncertain. Short-term reductions in emotional eating do not necessarily demonstrate durable change in coping,

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reward learning, or emotion regulation.

Recommendations

Based on the reviewed literature, the following recommendations are proposed:

1. **Use functional assessment.** Practitioners should identify emotional antecedents, thoughts, contexts, food cues, reinforcers, and consequences of emotional eating.
2. **Avoid moralizing food and body size.** Intervention should reduce shame and support self-compassion, not reinforce stigma.
3. **Differentiate emotional eating from eating disorders.** Screening should assess loss of control, binge episodes, compensatory behaviours, severe restriction, distress, impairment, and medical risk.
4. **Teach alternative emotion-regulation skills.** Treatment should strengthen reappraisal, problem-solving, mindfulness, distress tolerance, grounding, behavioural activation, and social support.
5. **Address restraint and rigid rules.** Clients with all-or-nothing dietary thinking may benefit from flexible, sustainable eating plans rather than strict restriction.
6. **Incorporate values and goal setting.** Goals should be personally meaningful, culturally appropriate, realistic, and flexible.
7. **Use mindful and acceptance-based strategies where appropriate.** These approaches can help clients observe urges and emotions without automatic behavioural response.

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8. **Consider social and cultural context.** Interventions should account for family eating patterns, food access, economic constraints, religious practices, and cultural meanings of food.

9. **Expand research methods.** Future studies should use longitudinal designs, EMA, culturally diverse samples, longer follow-up, clearer definitions, and outcomes beyond weight.

10. **Promote interdisciplinary care.** Where needed, psychologists should collaborate with dietitians, physicians, psychiatrists, and eating-disorder specialists.

Conclusion

Emotional eating is a complex psychological and behavioural phenomenon in which emotion, cognition, coping, reward, restraint, interoception, and social context interact to shape eating behaviour. It is not automatically a psychiatric disorder, not equivalent to binge-eating disorder, and not reducible to lack of willpower. Rather, it becomes clinically significant when food is repeatedly used as a primary strategy for managing distress or when emotion-linked eating contributes to impairment, shame, loss of control, or conflict with valued goals.

The literature indicates that negative emotions do not uniformly increase food intake. Emotional eating is heterogeneous and moderated by individual differences, discrete emotions, coping style, dietary restraint, reward sensitivity, social context, and learned history. Theoretical models, including Macht's five-way model, Gross's emotion-regulation framework, difficulties in emotion regulation, coping theory, negative reinforcement, restraint perspectives, reward models, and escape theory, together provide a strong basis for

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understanding the phenomenon.

Psychological interventions are therefore most defensible when they address the function of eating rather than food intake alone. CBT, mindfulness-based interventions, ACT-informed approaches, behavioural self-regulation, goal setting, feedback, and values-based work show promise, although evidence remains heterogeneous and long-term outcomes require further study. The most appropriate clinical stance is individualized, culturally responsive, non-stigmatizing, and psychologically informed. Emotional eating is best addressed by helping individuals develop flexible emotion-regulation skills, adaptive coping, meaningful goals, and alternative sources of comfort and reward.

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