DOI: 10.14744/DAJPNS.2025.00000
Dusunen Adam J Psychiatr Neurol Sci
2025;38:000-000

RESEARCH ARTICLE

The mediator role of experiential avoidance in examining the relationship between weight self-stigma and emotional eating in overweight and obese individuals

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ABSTRACT

Objective: This study examines the mediating role of experiential avoidance in the relationship between weight-related self-stigma and emotional eating among overweight and obese individuals.

Method: The study included 200 overweight and obese individuals. Participants completed a questionnaire consisting of a sociodemographic information form, the Emotional Eater Questionnaire (EEQ), the Weight Self-Stigma Questionnaire (WSSQ), and the Multidimensional Experiential Avoidance Questionnaire (MEAQ). The data obtained were analyzed using IBM SPSS and AMOS software packages.

Results: The results indicated that higher levels of weight-related self-stigma were significantly associated with increased emotional eating. The procrastination, distraction/suppression, and repression/denial subdimensions of multidimensional experiential avoidance had a significant mediating effect in this relationship. However, no significant mediation effect was observed for the behavioral avoidance, distress aversion, and distress endurance subdimensions.

Conclusion: The findings reveal that experiential avoidance strategies (particularly procrastination, distraction/suppression, and repression/denial) based on internal processes and providing automatic, short-term relief are key determinants in the relationship between weight-related self-stigmatization and emotional eating. Furthermore, no significant mediating effects were observed for dimensions reflecting the tendency to avoid external stimuli (behavioral avoidance) or long-term regulatory processes (distress aversion and distress endurance). A multidimensional assessment of experiential avoidance may contribute to more targeted and individualized interventions for overweight and obesity.

Keywords: Emotional eating, experiential avoidance, obesity, stigma, weight self-stigma

How to cite this article: Gulacan D, Sevincer GM, Kilincel O. The mediator role of experiential avoidance in examining the relationship between weight self-stigma and emotional eating in overweight and obese individuals. Dusunen Adam J Psychiatr Neurol Sci 2025;38:00-00.

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Received: February 04, 2025; **Revised:** August 15, 2025; **Accepted:** September 27, 2025

INTRODUCTION

Obesity is a disease characterized by excessive fat accumulation due to an impaired energy balance in the body (1). It has a high prevalence across all societies and is gradually becoming a global epidemic. According to the World Health Organization's (WHO) 2022 report, more than 2.5 billion (43%) adults aged 18 years and older worldwide are overweight, and more than 890 million (16%) of them are obese. Such a large-scale public health problem has serious negative consequences both individually and socially (2). This disease not only reduces the quality of life and functionality of individuals but also causes economic problems (3). Therefore, studies aimed at determining the factors that influence obesity will make a significant contribution to the field.

Stigmatization is one of the main negative experiences faced by overweight and obese individuals (4). Weight stigma affects people across all weight ranges. However, the rates of overweight and obese individuals who internalize the messages they are exposed to and stigmatize themselves based on their weight are considerably higher compared to other groups (5). Contrary to common assumptions, stigmatization has been shown to undermine obesity treatment efforts and contribute to significant declines in both psychological and physical well-being (6). Studies involving overweight and obese individuals have reported that those who internalize weight-related stigma are less likely to diet and exercise and are more prone to binge eating behavior (7). Similarly, findings indicate reduced emotional awareness, disrupted emotion regulation strategies (e.g., lower cognitive reappraisal and acceptance, higher suppression), and increased emotional eating tendencies among individuals with obesity (8). These patterns emphasize the need to address emotional eating, a factor widely recognized as a major obstacle to effective treatment.

Emotional eating is one of the most frequently used concepts to describe the psychological mechanisms underlying obesity (9). Escape theory defines emotional eating as the tendency to engage in binge eating behavior to reduce awareness, distract attention, or avoid negative stimuli. In other words, eating is considered a coping mechanism to escape from negative life experiences (10). Individuals with emotional eating tendencies often attribute greater psychological significance to food than its actual nutritional value. For them, food may function as a source of comfort, a reward, or a tool to control their emotions (11). Therefore, emotional eaters tend to consume large amounts of high-calorie food in a short time, in parallel with emotional changes, negative affect, and lifestyle factors. Studies have reported that emotional eating behavior is observed in more than 40% of obese individuals (9).

In recent years, there has been increasing evidence that experiential avoidance plays a mediating role in the relationship between weight-related self-stigma and emotional eating. Experiential avoidance refers to an individual's effort to avoid or control negative internal experiences (emotions, thoughts, bodily sensations) (12). However, there is no consensus in the literature regarding the nature of this construct. While some studies adopt a unidimensional approach, others focus on a multidimensional structure. These studies define six subdimensions of the concept (behavioral avoidance, distress aversion, procrastination, distraction/suppression, repression/denial, and distress endurance) and emphasize that the subcomponents of experiential avoidance may have unique clinical outcomes. Similarly, it has been suggested that a unidimensional approach to the construct may be insufficient for clinical interpretation, and that evaluating the sub-dimensions separately offers important contributions to both theoretical explanations and the determination of intervention goals (12). On the other hand, experiential avoidance is an important application area within different therapeutic approaches. For example, psychodynamic therapy focuses on the processes by which conscious material that is painful or threatening is discarded into the unconscious, whereas behavioral and cognitive therapies have addressed emotional and experiential forms of avoidance through specific techniques. Current approaches such as acceptance- and mindfulness-based Cognitive Behavioral Therapies (CBTs) (13), Dialectical Behavior Therapy (14), and Acceptance and Commitment Therapy (15) also underline the critical importance of this transdiagnostic concept. Therefore, a multidimensional assessment is important to identify specific areas of experiential avoidance related to emotional eating behavior in overweight and obese individuals and to design clinical interventions in a targeted and individualized manner.

The aim of this study was to examine the mediating role of experiential avoidance in the relationship between weight-related self-stigma and emotional eating among overweight and obese individuals.

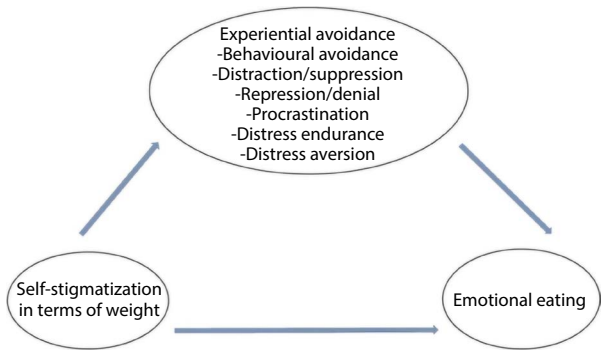

Figure 1. Mediating Role of Experiential Avoidance in the relationship between Weight-Related Self-Stigmatization and Emotional Eating Model.

First, it was hypothesized that higher levels of weight-related self-stigma would be positively associated with increased emotional eating. Second, specific dimensions of experiential avoidance (behavioral avoidance, distress aversion, procrastination, distraction/suppression, repression/denial, and distress endurance) were hypothesized to mediate this relationship. Figure 1 shows the mediation relationship between the variables.

METHODS

The study was conducted in accordance with the Declaration of Helsinki. It was reviewed by the Istanbul Gelisim University Ethics Committee at its meeting on 24.12.2021 (protocol number: 2021-40) and was deemed to comply with ethical guidelines. Data collection was carried out in accordance with the procedures specified in the forms, ensuring voluntary participation. The scale forms were administered face-to-face, and participants were informed about the study.

Participants

The inclusion criteria for the current study were: (1) participants were 18 years of age or older, and (2) had a Body Mass Index (BMI) of 25 kg/m^2 or higher (classified as overweight or obese). Exclusion criteria were: (1) pregnancy, (2) current or past psychiatric diagnosis or psychological/psychiatric treatment, and (3) incomplete or inconsistent responses. Individuals were screened via self-report and clinical interview to exclude psychiatric diagnoses. Participants were recruited from the outpatient clinics of Inönü University Turgut Özal Medical Center and voluntarily participated in the study. Data were collected through self-report questionnaires administered in a face-to-face format. Written informed consent was obtained from all participants before data collection, and the study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Power analysis was performed using G*Power software to determine the sample size. Based on the effect size estimates reported in Palmeira et al. (2018) (16), a minimum of 182 participants was required to achieve 95% statistical power with a 5% Type I error rate. The final sample was set at 200 participants to reduce the risk of data loss and to ensure sufficient power for the analyses.

Clinical Questionnaires

Weight Self-Stigma Questionnaire (WSSQ)

The WSSQ is used to assess self-stigmatization levels related to weight among overweight and obese individuals (17). Higher total scores indicate greater levels of self-stigmatization related to weight. The scale has two sub-dimensions: self-evaluation and fear of stigmatization. The scale has a minimum score of 12 and a maximum score of 60. The Cronbach's α value of the Turkish version of the scale was reported as 0.83 for the whole scale (18). In the current study, Cronbach's alpha coefficient was 0.91.

Emotional Eater Questionnaire (EEQ)

The EEQ is used to assess unhealthy eating attitudes associated with the emotions of overweight and obese individuals (19). It has three sub-dimensions: inability to curb food cravings, food types, and guilt. An increase in the total score indicates an increase in emotional eating behavior. The scale has a minimum score of 0 and a maximum score of 30. The Turkish validity and reliability study of the scale was conducted by Arslantas et al. (20). The Cronbach's α value of the Turkish form was found to be 0.81 for the inability to prevent food cravings sub-dimension, 0.57 for the type of food sub-dimension, 0.64 for the guilt dimension, and 0.84 for the whole scale. In the current study, Cronbach's alpha coefficient for the total scale was 0.89.

Multidimensional Experiential Avoidance Questionnaire (MEAQ)

The MEAQ is used to determine the extent of attempts to control or change negative emotions, thoughts, and internal experiences (12). It has six dimensions: behavioral avoidance, distress aversion, procrastination, distraction/suppression, repression/denial, and distress endurance. To facilitate its use in

Table 1: Assumption testing for the structural model: Autocorrelation and multicollinearity results

Model	Variable	Durbin-Watson	Tolerance	VIF
	WSSQ		0.44	2.29
	BA		0.46	2.17
	DA		0.38	2.63
EE	PR	1.95	0.51	1.98
	DS		0.59	1.70
	RD		0.81	1.24
	DE		0.72	1.39

WSSQ: Weight Self-Stigma Questionnaire; BA: Behavioral avoidance; EE: Emotional eating; DS: Distraction/suppression; RD: Repression/denial; PR: Procrastination; DE: Distress endurance; DA: Distress aversion.

clinical practice, a 30-item short form was developed in parallel with the sub-dimensions of the scale. The internal consistency reliability levels of the subscales in the Turkish form range between 0.76 and 0.87. An increase in the total score indicates a higher level of behavior related to the respective dimension (21). In the current study, Cronbach's alpha coefficients for the Multidimensional Experiential Avoidance Questionnaire subscales were as follows: behavioral avoidance (α=0.89), distress aversion (α=0.88), procrastination (α=0.78), distraction/suppression (α=0.91), repression/denial (α=0.86), and distress endurance (α=0.93).

Statistical Analysis

IBM SPSS Statistics 25.0 (SPSS Inc., Chicago, IL) and AMOS v21 programs were used for the evaluation of the research data. Reliability analyses were conducted for the scales used in the study, and Cronbach's alpha coefficients were taken into account. In the analysis of the data, descriptive categorical variables were expressed as number (n) and percentage (%), while quantitative variables were expressed as mean, standard deviation, skewness, and kurtosis values. Before conducting Structural Equation Modeling (SEM), assumptions regarding autocorrelation and multicollinearity were assessed. The Durbin-Watson statistic was examined to evaluate autocorrelation between residuals, and multicollinearity was assessed using Tolerance and Variance Inflation Factor (VIF) values. These results are reported in Table 1.

RESULTS

The dataset obtained from 200 participants was analyzed, and no missing values or univariate outliers were detected. Skewness and kurtosis statistics were calculated to evaluate the normality assumption of the total and subscale scores of the Emotional Eating Questionnaire, Weight Self-Stigma Questionnaire, and Multidimensional Experiential Avoidance Questionnaire. The fact that the skewness and kurtosis values of all variables were within the acceptable range of -1.5 to +1.5 indicates that the data were approximately normally distributed. In line with these findings, parametric statistical tests were used in the subsequent analyses. Descriptive statistics, including mean, standard deviation, skewness and kurtosis coefficients, as well as correlation coefficients between variables, are reported in Table 2.

Additionally, prior to conducting the Structural Equation Modeling, Durbin-Watson, tolerance, and VIF values were examined to assess potential violations of model assumptions. The results indicated no issues of autocorrelation or multicollinearity among the variables. These values are presented in Table 1.

Table 2: Descriptive statistics and correlation analysis among weight self-stigma, emotional eating, and dimensions of experiential avoidance

Variable	Mean±SD	Skewness	Kurtosis	1	2	3	4	5	6	7	8
1. WSSQ	35.9±11.2	-0.39	-0.95	—							
2. EE	28.3±6.7	-0.70	-0.40	0.76*	—						
3. BA	25.8±7.3	-1.12	0.50	0.55*	0.42*	—					
4. DA	24.7±7.9	-0.99	0.05	0.62*	0.54*	0.70*	—				
5. PR	23.5±6.6	-0.80	-0.18	0.55*	0.59*	0.57*	0.55*	—			
6. DS	25.3±7.3	-1.20	0.87	0.43*	0.45*	0.57*	0.57*	0.45*	—		
7. RD	16.1±7.1	0.49	-0.44	0.21*	0.30*	0.26*	0.24*	0.43*	0.27*	—	
8. DE	19.6±7.7	0.34	-0.95	-0.39*	-0.33*	-0.08*	-0.22*	-0.05*	-0.01*	-0.20	—

Pearson's Correlation was used. *p<.01; SD: Standard deviation; WSSQ: Weight Self-Stigma Questionnaire; BA: Behavioral avoidance; EE: Emotional eating; DS: Distraction/suppression; RD: Repression/denial; PR: Procrastination; DE: Distress endurance; DA: Distress aversion.

Table 3: Direct, indirect and total effects in models evaluating the dimensions of experiential avoidance: Bootstrap confidence intervals (confidence interval (CI) (Bias 95%)

	B	Lower	Upper
Direct effects			
WSSQ → BA	0.50*	0.42	0.59
BA → EE	0.04	-0.76	0.14
WSSQ → DS	0.43*	0.31	0.51
DS → EE	0.14*	0.04	0.22
WSSQ → RD	0.21*	0.09	0.32
RD → EE	0.14*	0.05	0.23
WSSQ → PR	0.64*	0.53	0.69
PR → EE	0.24*	0.16	0.35
WSSQ → DE	-0.39*	-0.52	-0.24
DE → EE	-0.04*	-0.13	0.07
WSSQ → DA	0.63*	0.55	0.70
DA → EE	0.11	-0.02	0.23
Indirect effects			
WSSQ → BA → EE	0.04	-0.01	0.09
WSSQ → DS → EE	0.05*	0.02	0.12
WSSQ → RD → EE	0.03*	0.01	0.06
WSSQ → PR → EE	0.15*	0.10	0.25
WSSQ → DE → EE	0.01	-0.04	0.04
WSSQ → DA → EE	0.06	-0.01	0.16
Total effects	0.76*	0.66	0.82

For direct effects, *p<0.05 bootstrap confidence intervals not including zero indicate statistical significance. For indirect effects, *p<0.05 bootstrap confidence intervals not including zero indicate significant mediation. WSSQ: Weight Self-Stigma Questionnaire; BA: Behavioral avoidance; EE: Emotional eating; DS: Distraction/suppression; RD: Repression/denial; PR: Procrastination; DE: Distress endurance; DA: Distress aversion.

Sample Characteristics

According to the collected data, 65.5% of the participants were female (n=131) and 34.5% were male (n=69); 38% (n=76) experienced obesity in childhood, and 51% (n=102) had a family history of obesity. The mean age was 28.52±7.83 years, ranging from 18 to 54 years. The mean height was 169.54±10.05 cm (range: 150–203 cm), and the mean weight was 88.75±17.5 (range: 58–134).

Mediation Analysis

To analyze the mediating effect of multidimensional experiential avoidance on the relationship between weight self-stigma and emotional eating, the relationship between the external latent variable weight self-stigma (WSSQ total) and the internal latent variable emotional eating (EEQ total) was first evaluated. Then, the mediating variable (MEAQ subdimensions) was added to the model. The significance of the mediation effect for the models was evaluated based on the 95% confidence interval obtained using the bootstrap method. An indirect effect whose confidence interval does not include "0" was considered statistically significant. The coefficients and significance (p) values of direct, indirect, and total effects in the models are shown in Table 3.

The results of the analyses showed a statistically significant positive relationship between weight-related self-stigma and emotional eating (β=0.76, 95% confidence interval [CI]=[0.66, 0.82]), (Appendix 1). Distraction/suppression mediated this relationship, while the direct effect remained significant (β=0.70), (Appendix 2). According to the model, distraction/suppression had a positive effect on emotional eating, and this subdimension explained 19% of emotional eating. When the fit indices of the model were examined, it was found to have good fit values [χ^2/df=1.89; Tucker-Lewis Index (TLI)=0.89; Normed Fit Index (NFI)=0.92; Comparative Fit Index (CFI)=0.96; Root Mean Square Error of Approximation (RMSEA)=0.062].

Similarly, when the mediating role of procrastination was examined, a significant relationship was observed. The relationship between weight-related self-stigmatization and emotional eating remained significant when procrastination was included in the model, but the direct effect decreased (β=0.61). According to the model, this subdimension explained 41% of emotional eating [χ^2/df=2.02; TLI=0.91; NFI=0.90; CFI=0.96; RMSEA=0.061], (Appendix 3). In the model including repression/denial, the relationship between weight-related self-stigma and emotional eating was also found to be statistically significant, with a decrease in the direct effect (β=0.73), and the rate of explained emotional eating was 60%. When the fit indices of the model were examined, they were within the recommended value ranges [χ^2/df=1.72; TLI=0.94; NFI=0.92; CFI=0.97; RMSEA=0.059], (Appendix 4). However, behavioral avoidance (β=0.04, 95% CI=[-0.01, 0.09]); distress endurance (p>0.05; β=0.01; 95% CI=[-0.04, -0.04]), and distress aversion (p>0.05; β=0.06; 95% CI=[-0.01, 0.16]) were not found to mediate the relationship between self-stigma and emotional eating.

Thus, the hypothesis that higher levels of weight-related self-stigma would be associated with increased emotional eating was confirmed. On the other hand, three of the hypotheses suggesting that the six subdimensions of experiential avoidance (behavioral avoidance, distress aversion, procrastination, distraction/suppression, repression/denial, and distress endurance) would mediate this relationship were confirmed. It was concluded that the procrastination, distraction/suppression, and repression/denial subdimensions of multidimensional experiential avoidance had a significant mediating effect on this relationship. However, no significant mediation effect was observed for the behavioral avoidance, distress aversion, and distress endurance subdimensions.

DISCUSSION

According to the findings of this study, there is a positive, significant, and strong relationship between weight-related self-stigma and emotional eating (β=0.76, 95% CI=[0.66, 0.82]). Therefore, it can be said that the findings are consistent with our first hypothesis. This result is in line with previous studies. In the literature, it has been reported that internalized weight stigma is significantly associated with unhealthy eating behaviors, especially uncontrolled and emotional eating (16). Furthermore, internalized weight stigma has been shown to be linked to binge eating symptoms, experiential avoidance patterns, and lower quality of life in individuals seeking weight loss (22).

The fact that internalized stigma, which is one of the difficulties frequently experienced by overweight and obese individuals, shows a strong relationship with emotional eating necessitates a more comprehensive evaluation of the psychological mechanisms underlying this relationship. Accordingly, the second hypothesis of the study tested whether the subdimensions of experiential avoidance (behavioral avoidance, distress aversion, procrastination, distraction/suppression, repression/denial, and distress endurance) play a mediating role in this relationship. Three of the hypotheses suggesting that the six subdimensions of experiential avoidance would mediate this relationship were confirmed. It was concluded that the procrastination, distraction/suppression, and repression/denial subdimensions of multidimensional experiential avoidance had a significant mediating effect on this relationship. However, no significant mediation effect was observed for the behavioral avoidance, distress aversion, and distress endurance subdimensions.

In the literature, there are no studies evaluating weight-related self-stigma and emotional eating variables, particularly those including the subdimensions of experiential avoidance. The main reason for this gap is the uncertainty surrounding the measurement of experiential avoidance. It has been reported that the most widely used scale, the Acceptance and Action Questionnaire-II (AAQ-II), inadequately reflects the multidimensional structure of experiential avoidance and primarily measures neuroticism and negative affect (23). The MEAQ, on the other hand, is considered a comprehensive tool that assesses experiential avoidance through six subdimensions and shows strong theoretical compatibility with third-wave therapies (23, 24).

According to Acceptance and Commitment Therapy (ACT), strategies such as distraction, suppression, and distress avoidance constitute the main forms of experiential avoidance. Conversely, endurance of distress refers to the individual's capacity to act in accordance with their values despite distressing internal experiences and is regarded as a key indicator of cognitive flexibility (25). Within this framework, the current findings indicate that ACT-based interventions decrease immature and neurotic defenses, increase mature defense styles and psychological flexibility, and significantly reduce body mass index (26). In the present study, strategies such as distraction and suppression showed significant mediation, whereas the mediation of distress endurance and distress aversion was insignificant. This suggests that the automatic components of experiential avoidance that provide short-term relief may be more directly related to emotional eating behaviors. Similarly, distress endurance or distress avoidance may be associated with broader domains of functioning.

Another dimension for which no significant mediation relationship was found is behavioral avoidance. In general, this refers to the tendency to physically avoid negative stimuli (27). Therefore, it can be said that emotional eating is mostly related to internal processes, while behavioral avoidance mainly involves avoiding external stimuli. On the other hand, a significant mediating relationship was found for the repression/denial dimension, which emphasizes unconscious internal processes. Within the framework of psychodynamic theories, this dimension is characterized by a lack of insight and difficulty in emotional expression. Puhl and Brownell (2003) (28) showed that, within the framework of negotiated social identity theory, obese individuals may openly

deny their overweight identity to protect their self-image against social stigmatization. The findings of the current study similarly support the semantic mediating role of the denial mechanism in the relationship between self-stigmatization and emotional eating. In addition, although there is limited information in the literature, it is thought that the relationship between self-stigmatization and emotional eating in relation to weight may be influenced by the short-term and automatic components of experiential avoidance that emphasize internal processes.

In this context, it can be said that the study contributes to the identification of specific experiential avoidance strategies, especially responses based on internal processes such as procrastination, distraction/suppression, and repression/denial, that sustain the relationship between internalized weight-related stigma and emotional eating in overweight and obese individuals. The findings contribute to structuring clinical interventions in a more targeted and individualized manner within the scope of ACT, psychodynamic, and cognitive-behavioral approaches.

In addition, the study has certain limitations. In the present study, since the gender distribution in the sample group was not balanced, female and male participants were not evaluated separately in the analyses. The gender imbalance in our sample (65.5% female) may limit the generalizability of the findings to male populations. Future studies should include gender-balanced samples. Findings on gender distribution in the relevant literature reveal that women are at greater risk of stigmatization and are more intensely exposed to discrimination than men. It is emphasized that this situation is further reinforced by stricter social norms regarding the female body and idealized body representations in the media (29). Similarly, although the relationship between weight-based stigmatization and psychological distress has been shown to be independent of gender, this relationship has been reported to be stronger in female samples (30). Therefore, future studies should explore gender-specific pathways and incorporate longitudinal designs to assess causal relationships. Furthermore, in the present study, obesity was evaluated only by BMI, which may be insufficient to reflect important parameters such as regional fat distribution. Future studies are recommended to consider complementary measures such as waist circumference, along with gender differences.

CONCLUSION

To our knowledge, this is the first study to assess the mediating role and specific dimensions of experiential avoidance in examining the relationship between weight-related self-stigma and emotional eating in overweight and obese individuals. Our findings suggest that emotional eating behavior increases as the level of weight-related self-stigma rises in overweight and obese individuals. In addition, it was concluded that the procrastination, distraction/suppression, and repression/denial subdimensions of experiential avoidance had a significant mediating effect on this relationship. However, no significant mediation effect was observed for the behavioral avoidance, distress aversion, and distress endurance subdimensions. These findings suggest that the relationship between weight-related self-stigma and emotional eating may be sustained by automatic and short-term responses that emphasize internal processes. This relationship is not explained by external processes and strategies associated with long-term, broader domains of functioning. From a clinical perspective, structuring interventions that target specific internal avoidance strategies within the frameworks of Acceptance and Commitment Therapy, psychodynamic therapy, and cognitive-behavioral approaches may help make interventions both more individualized and more effective.

Ethical Approval: The Istanbul Gelısım University Ethics Committee granted approval for this study (date: 24.12.2021, number: 2021-40).

Informed Consent: Informed consent was obtained from all participants.

Conflict of Interest: The authors declare that they have no conflict of interest.

Financial Disclosure: The authors declare that they have no financial support.

Acknowledgments: This research is derived from Master's thesis by Dilan Gulacan under the supervision of Mehmet Oguzhan Kılıncel and Guzin Mukaddes Sevincer.

Use of AI for Writing Assistance: Not declared.

Data Availability Statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Contribution Categories		Author Initials
Category 1	Concept/Design	D.G., G.M.S.
	Data acquisition	D.G.
	Data analysis/Interpretation	D.G.
Category 2	Drafting manuscript	D.G.
	Critical revision of manuscript	G.M.S., O.K.
Category 3	Final approval and accountability	D.G., G.M.S., O.K.

Peer-review: Externally peer-reviewed.

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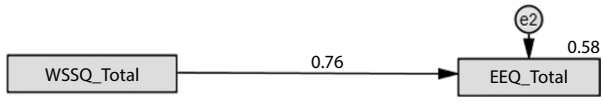
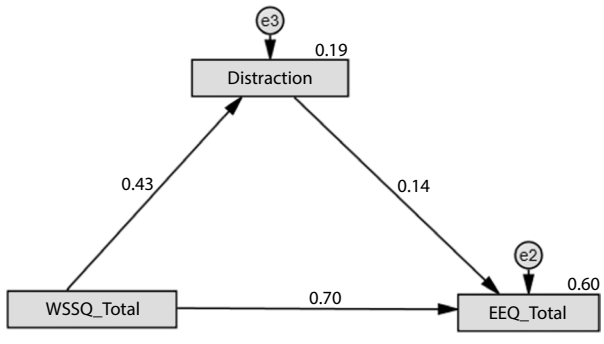


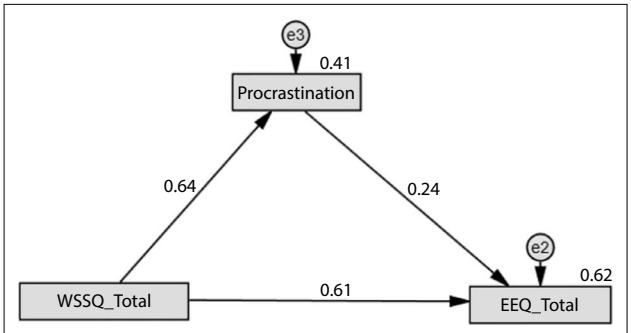
Appendix 1. The direct effect of weight self-stigma on emotional eating.



Effects	Distraction/ suppression		Emotional eating	
	β	Standard error	β	Standard error
WSSQ R^2 Total effect (c path)			0.764* 0.585	0.029
WSSQ R^2 (a path)	0.432* 0.598	0.042		
WSSQ (c′ path)			0.704*	0.030
Distraction/ suppression (b path) R^2			0.137* 0.187	0.045
Indirect effect			0.059 (0.023, 0.121)	

*p<0.05. WSSQ: Weight Self-Stigma Questionnaire.

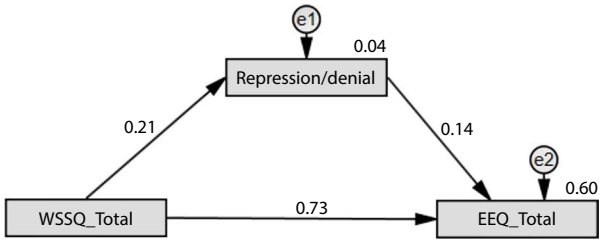
Appendix 2. The mediating effect of distraction/ suppression in the relationship between weight self-stigma and emotional eating.



Effects	Procrastination		Emotional eating	
	β	Standard error	β	Standard error
WSSQ R^2 Total effect (c path)			0.764* 0.585	0.029
WSSQ R^2 (a path)	0.640* 0.618	0.032		
WSSQ (c′ path)			0.608*	0.034
Procrastination (b path) R^2			0.244* 0.410	0.057
Indirect effect			0.156* (0.104, 0.253)	

*p<0.05. WSSQ: Weight Self-Stigma Questionnaire.

Appendix 3. The mediating effect of procrastination in the relationship between weight self-stigma and emotional eating.



Effects	Repression/ denial		Emotional eating	
	β	Standard error	β	Standard error
WSSQ R^2 Total effect (c path)			0.764* 0.585	0.029
WSSQ R^2 (a path)	0.209* 0.044	0.044		
WSSQ (c' path)			0.734*	0.027
Repression/ denial (b path) R^2			0.142* 0.602	0.043
Indirect effect			0.030 (0.012, 0.062)	

*p<0.05. WSSQ: Weight Self-Stigma Questionnaire.

Appendix 4. The mediating effect of repression/denial in the relationship between weight self-stigma and emotional eating.