IBN HALDUN UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF COUNSELING PSYCHOLOGY

MASTER'S THESIS

THE MEDIATING ROLE OF COGNITIVE EMOTION REGULATION STRATEGIES IN THE RELATIONSHIP BETWEEN CHILDHOOD MALTREATMENT AND EATING DISORDERS

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THESIS SUPERVISOR
ASSOC. PROF. ŞEYDA ERUYAR

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ISTANBUL, 2025

THESIS APPROVAL PAGE

This thesis has been read by us, and it has been decided that it is sufficient in terms of scope and quality to obtain a master's degree in the field of Counseling Psychology.

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It has been confirmed that this thesis has been written following all the standards set by Ibn Haldun University Graduate School of Graduate Studies/Institute for the Alliance of Civilizations.

Date of Submission Seal/Signature

ACADEMIC HONESTY ATTESTATION

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Full Name: Ayşe Özçiçek-Nazır
Signature:

ÖZ

ÇOCUKLUK DÖNEMİ KÖTÜ MUAMELELERİ İLE YEME BOZUKLUKLARI ARASINDAKI İLİŞKİDE BİLİŞSEL DUYGU DÜZENLEME STRATEJİLERİNİN ARACI ROLÜ

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Tez Danışmanı: Doç. Dr. Şeyda Eruyar
Ocak 2025, 161 Sayfa

Yeme bozuklukları (YB), fiziksel sağlığı, duygusal iyi oluşu ve sosyal işlevselliği derinden etkileyen ciddi psikolojik rahatsızlıklardır. Bu bozuklukların genellikle ergenlik ve erken yetişkinlik dönemlerinde ortaya çıktığı bilinmektedir. Her ne kadar YB'nin çoğunlukla genç kadınlarda görüldüğü bilinse de, son yıllarda tüm cinsiyet ve yaş gruplarında yaygın olduğu ve genellikle ciddi uzun vadeli sonuçlara yol açtığı giderek daha fazla kabul görmektedir. Erken yaşam dönemindeki olumsuz deneyimlerin yaygın bir biçimi olan çocukluk çağı kötü muameleleri (ÇKM), YB de dahil olmak üzere çeşitli psikopatolojilerle tutarlı bir şekilde ilişkilendirilmektedir. ÇKM ayrıca, duygusal süreçlerdeki bozulmalar ve duygu düzenleme güçlükleriyle bağlantılı olup, bu faktörlerin her ikisi de yeme bozukluklarıyla yakından ilişkilidir. Fakat, bilişsel duygu düzenleme stratejilerinin (BDDS) farklı ÇKM türleri ve YB arasındaki ilişkideki aracı rolü yeterince araştırılmamıştır. Bu çalışma, Türkiye'deki genel popülasyonda ÇKM türleri ile YB arasındaki ilişkide adaptif ve maladaptif BDDS'nin aracı rolünü incelemeyi amaçlamaktadır. Araştırmada, kesitsel bir tasarım benimsenmiş ve ağırlıklı olarak kadın (%89) ve ortalama yaşı 29,55 olan 352 katılımcıdan elde edilen veriler kullanılmıştır. Katılımcılar, Çocukluk Çağı Travma Ölçeği (CTQ-33), Bilişsel Duygu Düzenleme Ölçeği

(CERQ) ve Yeme Bozukluğu Değerlendirme Anketi (EDE-Q-13) dahil olmak üzere bir dizi geçerli ölçüm aracını ve sosyodemografik bilgi formunu doldurmuştur. Veriler, SPSS'in 29. sürümünde PROCESS Macro kullanılarak bir dizi aracı analiz yöntemiyle değerlendirilmiştir. Araştırma bulguları, maladaptif BDDS'nin cinsel istismar ve duygusal ihmal ile YB arasındaki ilişkide tam aracı rol oynadığını, diğer ÇKM türleri ile YB arasındaki ilişkide ise kısmi bir aracı rol üstlendiğini göstermiştir. Öte yandan, adaptif BDDS'nin, herhangi bir ÇKM türü ile YB arasındaki ilişkide aracı bir rol üstlenmediği bulunmuştur. Bu sonuçlar, ÇKM ve YB arasındaki ilişkide maladaptif BDDS'nin kritik rolünü vurgulamakta ve maladaptif stratejilerin kullanımını azaltmayı hedefleyen müdahalelerin önemine dikkat çekmektedir.

Anahtar Kelimeler: Bilişsel Duygu Düzenleme Stratejileri, Çocukluk Çağı Kötü Muameleleri, Gelişimsel Psikopatoloji, Olumsuz Çocukluk Çağı Deneyimleri, Yeme Bozuklukları.

ABSTRACT

THE MEDIATING ROLE OF COGNITIVE EMOTION REGULATION STRATEGIES IN THE RELATIONSHIP BETWEEN CHILDHOOD MALTREATMENT AND EATING DISORDERS

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Eating disorders (EDs) are severe psychological conditions that profoundly impact physical health, emotional well-being, and social functioning. These disorders predominantly manifest during adolescence and early adulthood. Although EDs primarily affect young women, there is a growing recognition of their prevalence across all genders and age demographics, often leading to serious long-term consequences. Childhood maltreatment (CM), a pervasive form of early-life adversity, has been consistently linked to a range of psychopathologies, including EDs. CM is also associated with disruptions in emotion-related processes and heightened difficulties in emotion regulation, both of which are closely tied to EDs. Despite these established relationships, the mediating role of cognitive emotion regulation strategies (CERS) between types of CM and EDs remains underexplored. This study aimed to examine the mediating role of adaptive and maladaptive CERS in the relationship between types of CM and EDs among the general population in Turkiye. A cross-sectional research design was employed, utilizing data obtained from a sample of 352 participants, predominantly female (89%), with a mean age of 29.55 years. Participants completed a sociodemographic questionnaire alongside validated measures, including the Childhood Trauma Questionnaire (CTQ-33), the

Cognitive Emotion Regulation Questionnaire (CERQ), and the Eating Disorder Examination Questionnaire (EDE-Q-13). A series of mediation analyses was conducted using the PROCESS Macro in SPSS version 29. The findings revealed that maladaptive CERS fully mediated the relationship between both sexual abuse and emotional neglect and EDs, whereas it partially mediated the relationship between other types of CM and EDs. However, adaptive CERS did not exhibit a mediating role between any types of CM and EDs. These results highlight the critical role of maladaptive CERS in the link between CM and EDs, emphasizing the need for interventions aimed at reducing reliance on maladaptive strategies.

Keywords: Adverse Childhood Experiences, Cognitive Emotion Regulation Strategies, Childhood Maltreatment, Developmental Psychopathology, Eating Disorders.

DEDICATION

One must still have chaos in oneself to give birth to a dancing star.

- Friedrich Nietzsche

This thesis is dedicated to the one who taught me to embrace my chaos and discover the beauty within it, inspiring me to hope, strive, and create.

ACKNOWLEDGEMENT

This section of the thesis is an excellent opportunity to thank all the incredible people in my life who embraced me with their emotional support, all the institutions that provided financial and academic assistance, and, of course, the developers of applications of artificial intelligence that enhanced this work. I am especially grateful to Grammarly for helping me refine the quality of my writing and teaching me academic English along the way. I am equally appreciative of ChatGPT for answering my questions without judgment, Typeset AI for facilitating access to academic sources, and Scite AI for offering valuable insights into the complex relationships between variables. I also deeply value the contributions of Canva and Napkin AI, which have enabled me to create visually engaging schemas and poster designs.

For the rest, I must include a brief note for the reader: as a literature major transitioning into psychology, this acknowledgment section may be a bit lengthier than expected.

I have chosen a career path in a different field, yet I am deeply grateful for the invaluable contributions of my professors in the Department of Turkish Language and Literature at Boğaziçi University. Their significant influence on my personal and academic development has been profound. The knowledge and insights I gained from them have greatly enriched my journey in the field of psychology. Their guidance not only solidified my academic foundation but also inspired me to pursue an academic career. I would like to extend my heartfelt gratitude to Dr. Kadir Gökgöz from the Linguistics Department at Boğaziçi University. He was the first person who encouraged me to consider academia, providing me with opportunities to engage in research in his labs, believing in my potential, and offering invaluable research experiences. The support he has provided for my success has established a strong foundation for my future research endeavors, and I will always cherish and appreciate the vital assistance he offered in my academic journey.

Changing fields, especially starting to learn about psychology from scratch, was far from easy. Despite my best efforts, I often battled feelings of incompetence, misfit, and

imposter syndrome. However, I consider myself fortunate to have been surrounded by people who believed in me and my potential. Additionally, psychology itself is a remarkable discipline, one that not only teaches you how to regulate yourself adaptively but also allows you to confront your inner fears and recognize your strengths. For this, I am profoundly thankful to the dedicated scholars who have devoted their lives and energy to advancing this transformative field.

I extend my deepest gratitude to Ibn Haldun University and the Department of Counseling Psychology for providing me with resources and opportunities. The scientific preparation year allowed me to transition into this field and find a path where I could thrive in both academic and personal fulfillment. I am also deeply thankful for the scholarship awarded to recognize my efforts and the part-time job that enabled me to learn and support myself financially. At this point, I must admit my appreciation to Prof. Dr. Üzeyir Ok. At a time when others were questioning my skills and whether I would be successful in the field, he recognized my potential. He provided not only emotional support for believing in me but also did his best to secure financial support for me. I will always be thankful for his contributions to my success.

Followingly, I would like to express my sincere thanks to TÜBİTAK for the scholarship provided under the Directorate of Science Fellowships and Grant Programmes (BİDEB) 2210/A National MSc/MA Scholarship. This financial assistance relieved me of the need to pursue full-time employment, allowing me to devote my time and energy fully to my studies. Additionally, I am grateful to the IHU Project Office for the funding received under BAP 2232, which enabled me to meet the financial requirements of this thesis. While the pursuit of knowledge is a driving force, I recognize that financial support plays an essential role in making academic endeavors achievable. Thanks to the support I received from these institutions, I was able to focus entirely on my studies and research.

Throughout the process of developing my thesis, I recognized an undeniable truth: the supervisor is the cornerstone of this journey. I came to appreciate that having a supportive and attentive supervisor is a significant advantage, and I consider myself particularly

fortunate in this regard. I am deeply grateful to my supervisor, Assoc. Prof. Şeyda Eruyar, for her invaluable guidance and support throughout this experience. From our first meeting, I admired her as a role model in the field—her intelligence, dedication, and exceptional communication skills made a lasting impression on me. I feel incredibly lucky to have been accepted as her thesis student. Before we met, I struggled to navigate the vast literature and define a clear research focus. Her mentorship provided the clarity and direction I needed, empowering me to approach my studies with confidence. I sincerely appreciate the time and effort she invested in enhancing the quality of this research. This work might not have reached completion without her. I am profoundly thankful for her guidance. I adore her; she is truly exceptional.

I don't know where to begin to thank my family, whose unconditional love and unwavering support have been the most precious constants in my life. At every fall, every moment of self-doubt, they were there to remind me of my worth and to show me their pride, no matter who I am or where I stand. It took me a while to fully realize this, but throughout this journey, I've internalized it deeply, carrying it forward as one of the most significant lessons of my life.

> Mom, I love you beyond words. Thank you for being my best friend and creating so many unforgettable moments with me—even the simplest ones, like turning on the TV just to chat without watching anything. Thank you for listening to my endless complaints, for getting angrier than I am with those who upset me, and for caring so deeply about my opinions. Above all, thank you for constantly reminding me, without a shred of doubt, that I am worthy of the very best.
>
> My dear dad, your care and dedication mean the world to me. Thank you for calling to check on me each morning, for noticing and fixing things I didn't even realize were broken, and for building things that I can proudly show off and say, "My dad made this for me." It makes me feel so cherished. I apologize for not always watching all the videos you send on WhatsApp, but please know how much I love and care about you—and I know, without a doubt, that you feel the same for me.

Yusuf, my dear brother and the only person I know who genuinely enjoys being the middle child. Your ability to find joy in everything inspires me. Thank you for sharing with me your favorite songs and the ones you sang—they never fail to brighten my day. I am so proud of the path you've carved for yourself. Watching you embrace life with peace and happiness has taught me that when you pursue what truly fulfills you, life brings beauty naturally, without force.

And my little Elif, my sister, I know you will be the one who will translate all these to everyone. I am so proud of the amazing person you've become. Thank you for making me feel like I have played even a tiny role in your success—it makes me feel valued and motivates me in ways I can't express. I know you'll achieve remarkable things, no matter which path you choose. I know, it is a bit irritating that I love teasing you and Yusuf, but unfortunately, that's what older sisters do best.

Family is truly irreplaceable. The love, lessons, and laughter we share are unmatched, and I'm endlessly grateful to have you in my life.

True friendship is rare—a bond where one can be fully accepted without pretense, a connection that becomes more meaningful and harder to find with age. My dearest friends, Beyza Nur Doğan Vatansever and Gizem Yıldırım Cinoğlu, are two exceptionally creative and successful women in their respective fields. They are not just friends but treasures in my life. For over a decade, their support has been a source of strength, even across distances. They have stood by me through my struggles, my highs and lows, and the times when I felt utterly lost in my thoughts, overwhelmed by the rollercoaster of emotions. Without judgment, they embraced every change—my challenges, successes, and moments of self-doubt—offering unwavering comfort and understanding when I needed it most. From them, I have learned invaluable lessons, not only about resilience and creativity but also about the profound beauty of unconditional friendship.

Thank you, Beyza and Gizem, for being my anchors, my cheerleaders, and my closest friends in every sense of the word.

Finally, I want to express my deepest gratitude to my beloved husband. His support in every sense and profound understanding have been the cornerstone of this thesis's success. I genuinely believe that without his incredible generosity and help since the moment we met, I would not have had the courage to pursue my passion for psychology or even begin to write this thesis. His presence in my life has made all the difference, and for that, I am eternally grateful.

During the COVID-19 pandemic, I found myself at my lowest, having quit my job and feeling overwhelmed by self-doubt, hopelessness, and a deep sense of being lost. I shared with him my dissatisfaction with my career and my struggles with insecurity and lack of confidence. Despite my doubts and fears, I confessed my dream of pursuing an academic career in psychology, even though it seemed far out of reach. From that moment, he became my guiding light, doing everything in his power to support me. As a doctor in the field, he shared his knowledge generously, spending countless hours discussing psychological concepts with me.

When I felt overwhelmed by the challenges ahead, he encouraged me with the timeless words of Lao Tzu: "*A journey of a thousand miles begins with a single step*." Those words became a touchstone for me. In moments of doubt and insecurity, he encouraged me with Freud's words: *"One day, in retrospect, the years of struggle will strike you as the most beautiful."* He taught me to find joy in the journey, to love and accept myself, and to embrace my flaws. Though I eventually found my way in this field, the foundation of everything I know today rests on what he taught me.

However, the truth is, what makes me most grateful to him is not the knowledge he shared but the unwavering emotional support, patience, guidance, and example of humanity he set for me. Meeting him marked the beginning of a new chapter in my life. Through his love and care, I learned to be kind without expecting anything in return and to find happiness in others' joy. He helped me understand my emotions, as well as empathize with others. He gently guided me out of the narrow world where only my struggles mattered and helped me see and appreciate the people around me. He taught me that others

are not the recipients of my anger or impatience but rather deserving of kindness and understanding. His love has made me a better daughter, sibling, friend, colleague, and, most importantly, a better version of myself. Every meaningful relationship in my life has flourished with his presence.

My dear, you are the greatest blessing in my life. I often find myself wondering what I did to deserve you, and no matter the reason, I am incredibly grateful for it. Today, I know with certainty that whatever decisions I make, you will stand by me without hesitation. And I also know that I could never willingly make a decision that would take me away from you, as even the thought of separation is unbearable.

And, of course, my dear, I also thank you for the coffee machine you so thoughtfully gifted me—it saved me countless hours in completing this thesis.

For all that you are and all that you bring to my life, my gratitude is boundless. This work is dedicated to you, my greatest source of support and cherished partner.

December, 2024 - January, 2025

ISTANBUL

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AN	Anorexia Nervosa
APA	American Psychological Association
BED	Binge Eating Disorder
BN	Bulimia Nervosa
CBT	Cognitive Behavior Therapy
CBT-BN	Cognitive Behavior Therapy-Bulimia Nervosa
CBT-E	Enhanced Cognitive Behavior Therapy
CDC	U.S. Centers for Disease Control and Prevention
CEA	Childhood Emotional Abuse
CEN	Childhood Emotional Neglect
CERS	Cognitive Emotion Regulation Strategies
CM	Childhood Maltreatment
CPA	Childhood Physical Abuse
CPN	Childhood Physical Neglect
CSA	Childhood Sexual Abuse
DBT	Dialectical Behavior Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDs	Eating Disorders
ER	Emotion Regulation
ICD	International Classification of Diseases
OP-OC	Overprotection-Overcontrol
OSFED	Other Specified Feeding or Eating Disorder
PTSD	Post-Traumatic Stress Disorder
WHO	World Health Organization

CHAPTER I

INTRODUCTION

1.1. Context and Background

Eating disorders (EDs) are significant global concerns. Research indicates that 0.6% to 2.4% of young men and 5.5% to 17.9% of young women face eating disorders during early adulthood (Silén & Keski-Rahkonen, 2022). Eating disorders demand particular care, as they often lead to some of the most serious outcomes among psychological disorders (Arcelus et al., 2011; Xintong, 2023). They negatively affect individuals' social and personal lives (American Psychological Association [APA], 2013). There is a high comorbidity with other mental health issues, including PTSD (Rijkers et al., 2019), personality disorders (Martinussen et al., 2016), and mood disorders (Godart et al., 2015). Approximately 53% of those with EDs also suffer from anxiety, while 43% experience depression (Ulfvebrand et al., 2015). Furthermore, EDs can lead to serious physiological complications, including issues related to the gastrointestinal, endocrine and metabolic, hematological, cardiovascular, renal, reproductive, and neurological systems (Dalle Grave et al., 2021; Westmoreland et al., 2016). In cases that result in obesity, there is a heightened risk of high cholesterol, hypertension, diabetes, heart disease, and cancer (Wassenaar et al., 2019). Consequently, numerous studies investigate the underlying causes, potential triggers, or key factors contributing to the development of EDs. Childhood maltreatment (CM), which is known to be associated with various psychopathologies (Cay et al., 2022), has been shown to predict the onset of EDs (e.g., Brewerton, 2007; Caslini et al., 2016; Molendijk et al., 2017; Solmi, Radua, et al., 2021; Trottier & MacDonald, 2017). However, further research is needed to identify the mechanism between the different types of CM and the development of eating disorders.

The relationship between CM and the development of EDs is well-documented; however, the mediating factors that either strengthen or weaken this connection remain uncertain. Current research indicates that emotion regulation plays a significant role in the emergence of various psychopathologies (Aldao et al., 2010; Kimhy et al., 2016; McLaughlin et al., 2020). Numerous studies have demonstrated that difficulties in emotion processing and regulation serve as potentially significant mediators between CM and EDs, as well (Burns et al., 2012; Ghanei et al., 2020; Moulton et al., 2015; Rabito-Alcón et al., 2021; Racine & Wildes, 2015). As Garnefski et al. (2001) emphasize, even though the concept of emotion regulation is helpful, the concept itself is quite complex. More specifically, it includes a wide range of aspects of life, such as social, behavioral, biological, and conscious and unconscious cognitive processes (Thompson, 1991). Therefore, focusing on one aspect at a time can provide a detailed understanding of its significance in the development of psychopathology. The cognitive theory of emotion regulation by Garnefski et al. (2001) concentrates on cognitive and conscious self-regulatory aspects of emotion regulation. Therefore, this theory does not focus on the issues of dysregulation and difficulty in emotion regulation; rather, it examines different cognitive strategies for regulating emotions, evaluating their long-term adaptability. It signifies that based on the use of certain strategies' long-term impacts, they are categorized as adaptive and maladaptive.[1] Even though there is not much literature demonstrating the role of CERS in between CM and EDs, it was found that maladaptive CERS shows a more substantial positive impact compared to a negative impact of adaptive CERS in the relationship between CM and EDs (Dawson et al., 2022).

1.2. Research Gap

A substantial body of literature underscores the link between childhood maltreatment (CM) and eating disorders (EDs) (Emery et al., 2021; Moulton et al., 2015; Rossi et al., 2024). Several studies specifically focused on the types of CM and found that they

[1] The original study (Garnefski et al., 2001) categorized strategies as more adaptive or less adaptive. However, in the current study, to eliminate possible confusion, simply adaptive and maladaptive labels were utilized to refer to more/less adaptive categorization. A detailed explanation can be found in the section titled "2.3.3.1 Cognitive Emotion Regulation Strategies (CERS)" in Chapter 2.

significantly predict EDs. For instance, research has demonstrated that childhood physical abuse (CPA) significantly predicts the onset of eating disorders, including anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), while also influencing the severity of these disorders (Borg et al., 2022; Caslini et al., 2016; Kovács-Tóth et al., 2022). Similarly, while conflicting findings exist, childhood sexual abuse (CSA) has also been linked to AN, BN, and BED (O'Loghlen et al., 2023; Talmon & Widom, 2022). Furthermore, childhood emotional abuse (CEA) is recognized as a strong predictor of disordered eating patterns, particularly BN and BED (Akgöz Aktaş et al., 2023; Vajda & Láng, 2014). Although CEA has been somewhat underexplored in comparison to other forms of abuse, Burns et al. (2012) found that it serves as the strongest predictor of disordered eating behaviors.

Despite several studies investigating the relationships between various types of CM and EDs, there is scarce evidence on different types of CM collectively, aside from systematic reviews or meta-analyses. In terms of neglect, research indicates that both physical neglect (Kimber et al., 2020) and emotional neglect (O'Loghlen et al., 2023) are associated with EDs; however, their significance in relation to EDs has not been adequately explored, as the primary focus remains predominantly on abuse (Talmon & Widom, 2022). This highlights the necessity for further investigation into the role of both neglect and other maltreatment types in relation to EDs.

Additionally, studies have identified a significant association between parental overprotection and overcontrol (OP-OC) and EDs (Gruber et al., 2020). Nevertheless, very few studies have investigated this relationship, and none have included other types of CM within the same research framework. Thus, it is required to research the relationship between parental OP-OC and various forms of maltreatment concurrently to facilitate comparisons within a single study. Overall, the impact of all forms of CM on EDs has not been sufficiently emphasized. The literature demands additional research to clarify the connections between all forms of maltreatment and EDs within a unified study framework.

The existing literature underscores the significant mediating role of emotion regulation (ER) in the relationship between CM and EDs. Research demonstrates that individuals with a history of CM frequently encounter challenges in ER, which can precipitate disordered eating behaviors, including restrictive eating, binge eating, or purging (Burns et al., 2012; Rabito-Alcón et al., 2021). Notably, the effects of childhood sexual and emotional abuse on the symptomatology of EDs appear to be mediated by ER difficulties, such as a lack of emotional clarity (Tilstra-Ferrell et al., 2023). Additionally, emotional abuse and neglect have been established as strong predictors of EDs, with ER challenges mediating these relationships (Burns et al., 2012; Racine & Wildes, 2015). However, there is a significant gap in the literature concerning the role of ER in the relationship between physical abuse and neglect as predictors of EDs. Furthermore, although overprotective parenting styles have been linked to emotional dysregulation and disordered eating behaviors (Iqbal et al., 2023), the limited number of studies in this area restricts the drawing of definitive conclusions. Therefore, further research is warranted to explore the mediating influence of ER across all forms of CM and their association with EDs.

Recent literature has begun to investigate the role of cognitive emotion regulation strategies (CERS) and has identified that certain maladaptive strategies, such as catastrophizing and rumination, mediate the relationship between specific types of CM, including emotional neglect, emotional abuse, and sexual abuse, and EDs (Dawson et al., 2022; Musetti et al., 2023). However, studies focusing specifically on CERS within this framework are alarmingly sparse. More specifically, comprehensive information regarding all types of CM in this context is notably lacking. Furthermore, research addresses difficulties in emotion regulation and maladaptive strategies that are relatively more prevalent; however, the possible protective role of adaptive CERS, such as cognitive reappraisal, remains underexplored. Limited studies examining this relationship highlight its significant role (Dawson et al., 2022).

Addressing these gaps—particularly the relationship between all types of CM and EDs and the investigation of both adaptive and maladaptive CERS as mediators—holds the

potential to yield significant insights for the development of targeted and effective interventions for individuals affected by various forms of CM and EDs.

1.3. Theoretical Framework

This study utilizes a developmental model to interpret the relationship among the variables in a transdiagnostic approach. Based on the developmental model by McLaughlin et al. (2020), CM can severely impact individuals, leading to various psychopathologies. While CM is a key predictor, other mechanisms influenced by CM also contribute to the emergence of psychological disorders. Emotion-related processes, including challenges in emotion regulation and the use of ineffective regulation strategies, are one of these mechanisms. Thus, this model posits that CM leads to the development of several psychopathologies via emotion-related processes. This study investigates the potential impact of all types of CM on the total score of EDs through adaptive and maladaptive CERS. The conceptual framework is illustrated in Figure 1.1.

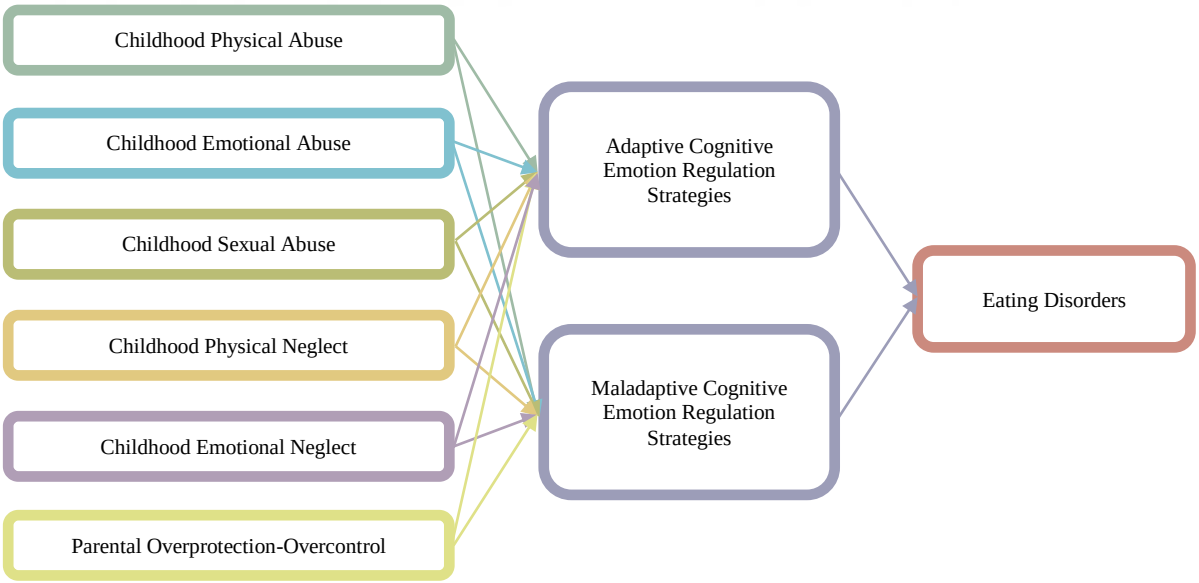


Figure 1.1. The Conceptual Framework

1.4. Research Aim

The aim of this research is to explore the mediating role of adaptive and maladaptive cognitive emotion regulation strategies (CERS) in the relationship between different forms of childhood maltreatment (CM) and the development of eating disorders (ED) among the general population in Turkiye.

CHAPTER II

LITERATURE REVIEW

The aim of this chapter is to provide a comprehensive literature review to elucidate the complex relationship between childhood maltreatment (CM), eating disorders (EDs), and emotion regulation. It specifically focuses on investigating the role of cognitive emotion regulation strategies (CERS) in the relationship between CM and EDs. In this chapter, the general background is provided, followed by an explanation of the research framework. The general background included the diagnostic criteria of eating disorders comparing DSM-IV, DSM-5, and ICD-11, the age of onset, prevalence, treatment techniques, and negative consequences on individuals' social, physical, and psychological health; childhood maltreatment, including its definition, detrimental impacts, prevalence and detailed information of its types and emotion regulation with a specific focus on cognitive emotion regulation strategies. The existing literature on the interrelationships between these variables is reviewed, highlighting the connections between eating disorders and childhood maltreatment, eating disorders and emotion regulation, and emotion regulation and childhood maltreatment. Finally, the scope of the current study is provided by identifying gaps in the literature and outlining the aims of the study.

2.1. Research Framework

Developmental approaches to psychopathologies are based on interactions of various aspects, such as the biological, emotional, cognitive, social, and unconscious processes of one’s life and their contributions to developing adaptive or maladaptive behaviors of the individual across the lifespan (Kerig & Alexander, 2024). Scholars have highlighted a significant point that there are variations among individuals in terms of their susceptibility to developing disorders; for instance, some individuals adopt several maladaptive responses related to their disorders, while some others, even though they bear the

maladaptive outcomes, do not develop psychopathologies. This issue is defined by two principles from von Bertalanffy's (1968) general systems theory: equifinality and multifinality (Cicchetti & Rogosch, 1996). As Cicchetti and Rogosch explain, equifinality signifies the same final point, which is reached from various starting conditions and through different processes. For example, individuals with different socioeconomic backgrounds, genetic makeup, ethnicity, family environment, education level, or life challenges encountered can develop eating disorder symptoms. On the other hand, multifinality refers to the concept that the same pathways can lead to different outcomes. In other words, facing a negative situation does not always result in the development of psychopathology. Two individuals may encounter the same challenge, and while one might develop a disorder, the other may not necessarily experience the same outcome.

Multifinality, specifically, has a significant role in the development and prevalence of transdiagnostic approaches that aim to identify the fundamental underlying processes of multiple and, in most cases, comorbid psychological disorders (Mansell et al., 2009; Nolen-Hoeksema & Watkins, 2011). Traditionally, scholars were more inclined to create distinct diagnostic categories; however, it was recognized that the boundaries between these categories are not solid but transitive and carry commonalities (Barch, 2020). This understanding led scholars to discover transdiagnostic criteria related to various disorders. In other words, the principle of multifinality encouraged studies that define transdiagnostic factors, common underlying features, of psychological disorders.

McLaughlin et al. (2020), prominent psychologists in the field of developmental psychopathology, developed a transdiagnostic model of developmental mechanisms to explain the links between childhood trauma exposure and the development of psychological disorders throughout the lifespan. By referring to the literature, the paper argues that childhood trauma is a strong transdiagnostic factor, as it represents a common risk factor for various ranges of psychological disorders. The model describes three key transdiagnostic mechanisms that link childhood trauma to different forms of psychopathology. These transdiagnostic mechanisms are defined as social information processing (having biases regarding perceiving, identifying, and interpreting social cues;

increase in labeling cues as a threat), emotion processing (high emotional reactivity; emotion regulation difficulties), and accelerated biological aging (entering puberty earlier; aging in cellular structure). The model identifies these mediating factors as transdiagnostic mechanisms that link childhood trauma to psychopathologies.

The current research aims to adopt this transdiagnostic approach by implementing the developmental model proposed by McLaughlin et al. (2020) to investigate the relationship between childhood maltreatment and eating disorder psychopathology. Specifically, it examines the mediating role of cognitive emotion regulation strategies (CERS) within the emotion processing domain, which the model highlights as a crucial mechanism underlying the link between early trauma and the emergence of psychological disorders.

2.2. General Background

2.2.1. Eating Disorders

Eating disorders (EDs) are characterized by ongoing disruptions in eating or related behaviors, leading to changes in food consumption or absorption, which notably affect psychological well-being, physical health, or social functioning (APA, 2013; World Health Organization [WHO], 2024). EDs have become an increasingly prevalent global health concern, impacting individuals and healthcare systems worldwide because of its physical, psychological, social, and economic adverse consequences (Hambleton et al., 2022). Alongside their significant physical consequences such as gastrointestinal, endocrine and metabolic, hematological, cardiovascular, renal, reproductive, and neurological problems (Dalle Grave et al., 2021), EDs are strongly associated with psychological challenges such as anxiety (Bazo Perez et al., 2023), depression (Ogorenko & Kokashynskyi, 2023), and low self-esteem (Lagan et al., 2024). Socially, individuals with EDs often experience stigma and isolation that restrict individuals from seeking help (Kurdak et al., 2023).

EDs are a significant health concern affecting a large number of people worldwide. They typically manifest during adolescence (Solmi et al., 2021; Uhlhaas et al., 2023) and negatively impact individuals worldwide. While previous research suggested that eating disorders were more prevalent in Western societies, a recent literature review revealed that non-Western societies are also at high risk of developing EDs (Silén & Keski-Rahkonen, 2022). The review also highlighted that young adults, particularly women, are susceptible to developing eating disorders with 0.6% to 2.4% of young men and 5.5% to 17.9% of young women experience eating disorders in early adulthood. In fact, the reported prevalence of eating disorders may not fully capture the actual numbers because socioeconomically disadvantaged groups and males are less likely to acknowledge their need for assistance or to actively seek treatment (Sonneville & Lipson, 2018).

The DSM-5, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, classifies eating disorders within the broader category of feeding and eating disorders. This classification includes pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge-eating disorder, other specified feeding or eating disorders, and unspecified feeding or eating disorders. Among these, pica involves the persistent consumption of nonnutritive or nonfood substances, rumination disorder is characterized by repeated regurgitation of food that may be re-swallowed or expelled, and avoidant/restrictive food intake disorder is marked by extreme selectivity or lack of interest in food. These three disorders commonly emerge during infancy or childhood and, although they can persist into adulthood, their primary association with early development and limited prevalence in adult populations falls outside the scope of this research. As this study focuses on eating disorders typically manifesting during adolescence or adulthood, these childhood-onset conditions will not be explored in detail. The other disorders within the feeding and eating disorders cluster typically have an onset in adolescence or early adulthood; however, they may also manifest later in life. Although these disorders are closely interconnected, the diagnostic criteria for each are mutually exclusive. A detailed examination of these disorders, their symptom-based characteristics, contributing factors, and psychological and physical consequences are presented in the following sections.

2.2.1.1. Diagnostic and Clinical Overview of Eating Disorders

2.2.1.1.1. Anorexia Nervosa

Anorexia nervosa (AN), based on DSM-5 criteria, is characterized by ongoing restriction of energy intake, a strong fear of becoming fat or even putting on weight, persistent behaviors that hinder weight gain despite being significantly underweight, and a distorted perception of one's weight or shape leading to inability to recognize the significance of the situation due to low weight (APA, 2013). AN has two types, namely, the restricting type and the binge eating/purging type. In the restricting type of AN, individuals do not engage in binge eating and purging behaviors such as misuse of laxatives or self-induced vomiting in the last three months. Instead, weight loss primarily occurs as a result of dieting, fasting, and/or excessive exercise. On the other hand, a binging and purging type of AN exists with recurrent binging and purging episodes in the last three months.[2]

For individuals with AN, both ICD-11 and DSM-5 necessitate the presence of essentially the same clinical features (Quadflieg et al., 2023). Notably, there were some changes made between the DSM editions. Even though AN was already officially recognized as a disorder in DSM IV (APA, 1994) some changes were presented in DSM-5. One important change was standardizing the definition for "low weight." In DSM-IV, underweight is defined as a weight lower than 85% of the weight considered normal for individuals of the same age and height. However, the definition of "normal" can vary among individuals, and this ambiguity has contributed to diagnostic errors for some clinicians (Freidl et al., 2012). In contrast, the DSM-5 adopted BMI scores to diagnose AN and its severity, using a BMI score of 18.5 kg/m2 as the lower limit for the normal weight of adults (WHO, 1995). A BMI score between 17-18.49 kg/m^2 is classified as mild, 16–16.99 kg/m^2 as moderate, 15–15.99 kg/m^2 as severe, and below 15 kg/m^2 as extreme. Moreover, DSM IV required that individuals have to admit they have an extensive fear of gaining weight for the AN diagnoses. However, this necessity was eliminated in DSM-5. This means that irrespective of the articulation of the explicit fear of gaining weight or becoming fat,

[2] For a detailed explanation of binging and purging behavior, see section 2.2.1.2. Bulimia Nervosa (BN).

individuals can still be diagnosed with AN (Call et al., 2013). The final modification is the elimination of the amenorrhea criteria. This simply allows clinicians to diagnose individuals with regular or irregular menstrual periods with AN if they meet the other criteria.

The onset of AN typically occurs during adolescence or early adulthood (Ranzenhofer et al., 2022). Recent studies indicate a decreased age of onset for AN, even younger generations began to be diagnosed with AN (Favaro et al., 2019) and early onset of AN was observed prior to age of 14 (Grilo & Udo, 2021; Naydenova & Eyubova, 2022; Pruccoli & Parmeggiani, 2023; Watson et al., 2022). However, typically, the peak age for AN was found to be 15.5 years (Hebebrand et al., 2024). Furthermore, adolescent onset is defined as 15-18 years of age, and adult onset is defined as 19-24 years of age (Grilo & Udo, 2021). Based on the data shared in ICD-11, AN is diagnosed more frequently in females globally, with up to 10 times higher prevalence compared to males (WHO, 2024). Lifetime prevalence shows similarity in Eastern Europe, Asia, and Latin America, and among women, ranges from 0.8% to 6.3%. Although less is known about the prevalence of anorexia nervosa in males, there is evidence indicating an increase in its incidence and detection. Furthermore, it has been observed that laxative abuse is more common among females, while excessive exercise is more prevalent among males (WHO, 2024).

AN presents fatal dangers attributed to severe weight loss and organ failures associated with starvation (Xintong, 2023). It exhibits the highest mortality rates among psychiatric disorders (Mihoc et al., 2024; Westmoreland et al., 2022), with estimates suggesting that individuals with AN have a mortality risk approximately six times higher than that of the general population (Kaye & Bulik, 2021). It leads to severe medical complications, including bone density loss, hematologic abnormalities, cardiac and gastrointestinal dysfunction, endocrine disturbances, and neurological effects, all of which highlight the critical need for early intervention and comprehensive care (Brown & Mehler, 2015). The presence of comorbid psychiatric disorders, such as depression (Ho et al., 2016), substance use disorder (Willmore et al., 2017) and personality disorders (Cailhol et al., 2017), further exacerbate the risk of increased mortality and complicate treatment (Himmerich et al.,

2019). Additionally, in terms of increasing mortality rates, suicidal risk is 18 times higher compared to community controls among patients with AN (Mitchell & Peterson, 2020). Therefore, addressing these medical and psychological challenges is vital in formulating an effective treatment plan.

The complex nature of AN and its significant consequences require implementing effective and versatile treatments. Treatments can involve medication, psychotherapy, and inpatient implications to ensure sufficient nutrition is taken and hinder any type of suicidal attempts (Tuckwell, 2024). Early interventions are associated with positive outcomes, including restored weight, reduced emotional distress, and long-term adaptive behavioral changes (Olariike-Oyindasola et al., 2022). Additionally, it was found that individuals with anorexia nervosa show difficulty in accepting and regulating their emotions (Santos & Haynos, 2023) and are very likely to apply maladaptive emotion regulation strategies such as rumination (Leppanen et al., 2022). This highlights the importance of addressing emotion regulation issues in AN treatment (Leppanen et al., 2022; Rowsell et al., 2016). Various psychotherapy approaches were found to be effective in AN treatment. Family-based therapies are often recommended for treating adolescents and children with AN (Lock, 2018). On the other hand, cognitive behavioral therapy (CBT) was found effective in terms of achieving both physical and psychological recovery for adolescents (Baile & Rabito-Alcón, 2022) and adults with AN (Linardon et al., 2017). The enhanced version of CBT (CBT-E), consisting of approximately 40 sessions—double the length of standard CBT—offers a more comprehensive treatment by addressing both disorder-specific and broader psychopathological features and has been shown to provide effective and sustained outcomes for AN patients (Dalle Grave et al., 2013; Fairburn et al., 2013). Given the multifaceted challenges posed by anorexia nervosa, integrating tailored treatments that address both medical complications and underlying psychological factors, such as emotion regulation difficulties, is essential for achieving long-term recovery and improving overall patient outcomes.

2.2.1.1.2. Bulimia Nervosa

DSM-5 (APA, 2013) and ICD-11 (WHO, 2024) both define bulimia nervosa (BN) as the engagement in recurrent binge eating episodes followed by compensatory acts to prevent weight gain, regardless of body weight (except meeting the criteria for AN). Both sources require that for a diagnosis of BN, individuals must be preoccupied with thoughts related to their weight or shape, and their self-evaluation must be strongly influenced by their body weight and shape. The minimum prevalence of the symptoms for diagnosis requires the presence of binge eating behavior and inappropriate compensatory behaviors (or in other words, purging), i.e., self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, as well as engaging in diets, fasting, or excessive exercise, performed once a week for three months.

In DSM-5, binge eating behavior is defined by two criteria. First, it involves consuming an excessive amount of food in a specific time period, which exceeds what most individuals would eat in similar circumstances. Second, it involves feeling unable to control eating behavior during the episode. ICD-11 has similar criteria, but also includes a subjective component related to overeating. This means that even if the amount of food consumed is normal for most people, it might still be considered abnormal for the standards of that individual, and thus considered binge eating. The threshold for binge eating and compensatory behaviors has been reduced in DSM-V. In DSM IV (APA, 2000), the diagnostic criteria for bulimia nervosa outlined a minimum duration of the disorder of three months and necessitated the presence of binge-eating and purging behaviors occurring at least twice a week. The DSM-5, on the other hand, maintains the three-month minimum duration for diagnosis; however, it modifies the criteria to require that compensatory behaviors manifest at least once per week. This helps clinicians to effectively diagnose and provide assistance to younger individuals who have recently developed BN (Call et al., 2013). While reducing the minimum duration criteria, new specifications were added to determine the severity of the disorder. According to these criteria, engaging in inappropriate compensatory behavior 1 to 3 times per week is

considered mild severity, 4 to 7 times per week is moderate severity, 8 to 13 times per week is severe, and an average of 14 or more is considered extreme severity.

Research indicates both the age of onset and the prevalence rates of BN. It typically begins during adolescence or young adulthood (Favaro et al., 2019), with a mean age of onset at 18 (Volpe et al., 2016). BN typically occurs within the age range of 18 to 25 years. However, onset can also occur in older individuals, including those over 65 years old (T. J. Cooper, 2017). A systematic review conducted by Galmiche et al. (2019) demonstrated that BN is highly prevalent across the world, and its lifetime prevalence expanded from 3.5% to 7.8% in the last decade. The average duration of BN was found to be 8.3 years (Erford et al., 2013).

An early study (Witcher & Williamson, 1992) suggested that the duration of the disorder and the age at which it begins can impact the course of BN. Specifically, longer duration and older age at the onset of the disorder are associated with worsened symptoms, such as increased frequency of binge eating and purging, greater weight gain accompanied by more distorted body size estimations, and social withdrawal and isolation. On the other hand, it was found that early implications predict better outcomes and increase the chances of recovery in the case of patients with BN (Reas et al., 2000). Thus, it is crucial to emphasize the significant impact of early and effective interventions on the outcome.

Both pharmacological treatments and psychotherapies play pivotal roles in addressing BN. Pharmacotherapy is particularly beneficial when there is comorbidity with other mental disorders, malnutrition, and physical health issues (Himmerich et al., 2021). Psychotherapeutic interventions for BN encompass a wide range of approaches, including behavior therapy, focal supportive therapy, dietary counseling, psychodynamic psychotherapy, and both group and individual cognitive behavioral therapy (National Collaborating Centre for Mental Health (UK), 2004).

Enhanced cognitive behavior therapy (CBT-E) has been found to be the most effective psychotherapy for BN as it addresses various aspects of the disorder with a transdiagnostic

approach. This includes not only focusing on eating psychopathology but also addressing emotion regulation, perfectionism, and core low self-esteem (Hambleton et al., 2020). In conclusion, early intervention is crucial, and both pharmacological treatments and psychotherapies are essential in addressing bulimia nervosa. Enhanced cognitive behavior therapy (CBT-E) has emerged as particularly effective.

2.2.1.1.3. Binge Eating Disorder

In DSM-5, Binge eating disorder (BED) is recognized as a distinct disorder for the first time. Prior to that, in DSM IV, BED was categorized under the category of Eating Disorder Not Otherwise Specified. ICD-11 and DSM-5 define BED as recurrent binge eating episodes during which a person eats a larger amount of food compared to what most people would eat in a similar period of time and under similar circumstances and experiences a sense of losing control while eating at least once a week for three months. However, unlike Bulimia Nervosa (BN), patients with BED do not engage in inappropriate compensating behaviors to control calorie intake or weight gain.

According to DSM-5, individuals must have at least three of the following features associated with their binge eating episodes for the diagnosis of BED: 1) eating much faster than they normally do; 2) eating until feeling uncomfortably full; 3) eating large amounts of food even when they don't feel physically hungry; 4) eating alone because of embarrassment related to the amount of food they eat; and 5) feeling disgusted with themselves, depressed, or guilty after engaging in binge eating. These cognitions and behaviors are not required to be diagnosed with BED based on ICD-11 criteria; however, they have been mentioned as additional clinical features of BED. DSM-5 also provides criteria to define the current severity of the disorder. Based on that, engaging in binge eating disorder 1 to 3 times per week is considered mild severity, 4 to 7 times per week is moderate severity, 8 to 13 times per week is severe, and an average of 14 or more is considered extreme severity.

Based on the data provided by ICD-11, BED typically occurs in adolescence or young adulthood, but it can also begin in later adulthood (WHO, 2024). In a study involving women aged 60 and over with BED, it was discovered that 33.3% experienced onset of BED before the age of 40, 17.9% experienced onset between the ages of 40 and 55, and 48.7% experienced onset at age 56 or older (Kilpela et al., 2023).

Stressful life events play a significant role in developing BED symptoms (Degortes et al., 2014; Kilpela et al., 2023; Pike et al., 2006). It was observed that the prevalence of BED also increased during the COVID-19 lockdown due to elevated stress levels and changes in routines and eating habits (Mumtaz et al., 2022). During the years 2018-2020, the global prevalence of binge eating disorder (BED) was estimated to be 0.6-1.8% in adult women and 0.3-0.7% in adult men (Giel et al., 2022).

It is significant to note that there is a significant number of people who do not meet the full criteria for BED; however, they engage in binge eating behavior. A study found that while the prevalence of BED was 1%, the prevalence of binge eating behavior was 6.3% (Nagata et al., 2023). It has been suggested to be the most common eating disorder; however, it often remains unrecognized by individuals, making it difficult to seek help (Scrandis & Arnow, 2023).

For the treatment of BED, a variety of therapeutic models have been utilized. Established approaches include CBT, dialectical behavior therapy (DBT), interpersonal psychotherapy (IPT), behavioral weight loss treatment, and pharmacotherapies using antidepressants, anticonvulsants, anti-obesity medications, and central nervous system stimulants (Berkman et al., 2015). More recently, integrative-cognitive therapy, emotion regulation skills training, emotion-focused therapy, e-mental health interventions, and advancements in behavioral weight loss treatment have emerged as innovative methods (Hilbert, 2023). However, CBT-E is the most suggested treatment method for BED interventions (Aigner et al., 2011; APA, 2006). Similarly, in their comprehensive review, Berkman et al. (2015) demonstrated that CBT and second-generation antidepressants, lisdexamfetamine, and topiramate provide effective treatment outcomes, while behavioral

weight loss programs and certain medications such as atomoxetine and dietary supplements show limited or insufficient effectiveness. Consequently, it can be said that BED can be developed at any age and mostly after a stressful life event. This is why working on cognition and emotional aspects through CBT interventions can provide better outcomes.

2.2.1.1.4. Other Specified Feeding or Eating Disorders

The disorders in this category, as defined by DSM-5 and ICD-11, share similar characteristics with other feeding and eating disorders. They are noted to pose a significant risk or damage to health, cause clinically significant distress, or result in notable impairment in social, occupational, or other important areas of functioning. However, these disorders do not fully meet the diagnostic criteria within this specific cluster, and their symptoms cannot be more accurately explained by any other mental, behavioral, or neurodevelopmental disorder. Unlike ICD-11, DSM-5 provides some example disorders in this category, following as:

Atypical anorexia nervosa: In this case, the individual exhibits all the symptoms of AN, except for significantly low weight. Their weight falls within or above the normal range.

Bulimia nervosa (of low frequency and/or limited duration): When all criteria for bulimia nervosa are met except for the duration and/or frequency of binging and inappropriate compensatory behaviors.

Binge eating disorder (of low frequency and/or limited duration): When all criteria for binge eating disorder are met except for the duration and/or frequency of binge eating behavior.

Purging disorder: In this case, individuals engage with purging behavior to control or lose weight with the absence of binge eating episodes.

Night eating syndrome: There are recurrent episodes of night eating, involving waking up from sleep to eat or consuming excessive food after dinner. Individuals are aware of and can recall their eating. The situation cannot be better explained by the individual's sleep-wake cycle, social or cultural norms, medical disorders, or the effects of medication.

The reason why OSFED consists of a variety of disorders, it is challenging to provide a clearer picture of their prevalence, onset of age or treatment. However, it is estimated that the prevalence of OSFED ranges from 0.6-11.5% in young women and 0.2-0.3% in young men (Silén & Keski-Rahkonen, 2022) with an onset at 18 years (Mustelin et al., 2016). Additionally, it is highlighted that prevention and treatment strategies must be tailored to the individual and their needs (Treasure et al., 2022).

2.2.1.2. Symptom-based Characteristics of Eating Disorders

There are five key components that must be considered to assess EDs based on the diagnostic criteria and symptoms. These components include eating restraint, over-evaluation of shape and weight, body dissatisfaction, bingeing, and purging. It's essential to define each of these components clearly for the purpose of this research.

Eating restraint refers to the deliberate act of restricting one's food intake in order to attain or sustain a desired body weight (Laessle et al., 1989). According to a literature review that analyzed 190 papers published between 1995 and 2023, adolescents and women in their early 20s are highly influenced by the cultural ideal of being thin and petite and are quite likely to adopt restrictive diets and avoid consuming enough nutrition for their bodies (Son & Kwon, 2024).

Over-evaluation of shape and body signifies the experience of individuals who define their self-worth based on their physical appearance, specifically, their body weight and shape (C. Fairburn & Harrison, 2003). Significantly, valuing oneself based on body weight is not related to actual weight, shape, age, or gender. A meta-analysis has shown that the over-evaluation of body shape is not related to Body Mass Index (BMI) or other

demographic variables such as age, sex, or ethnicity. Conversely, individuals with clinical levels of over-evaluation reported significantly higher levels of depressive symptoms, eating pathology (such as eating restrains, binge eating frequency, shape concern, and weight concern), and lower levels of self-esteem, when compared to those with non-clinical levels of over-evaluation (Linardon, 2017).

Body dissatisfaction refers to negative evaluations of one's body shape, size, weight, or muscle tone and often occurs due to a perceived mismatch between one's actual body and the ideal body (Grogan, 2017). Although body dissatisfaction was not included as a criterion for BED in DSM-5, it is considered the key predictor for the onset of future bingeing-purging spectrum eating disorders (restricting type AN, purging type AN, BN, and BED) by scholars (Rohde et al., 2015; Stice et al., 2017, 2019).

Bingeing behavior is characterized by recurrent episodes of consuming significantly large amounts of food in a short period of time, accompanied by feelings of loss of control over eating behaviors (APA, 2013). Binge eating behavior is necessary for the diagnosis of BED and BN. However, it can be experienced in AN with purging behavior as well.

Purging is a compensating act that typically follows a binge eating episode and is performed to control weight gain. It involves intentionally evacuating substances from the body, typically through self-induced vomiting or misusing drugs such as laxatives and diuretics, performing excessive exercise, and dieting or fasting to decrease calorie intake (APA, 2013).

2.2.1.3. Factors Contributing to the Development of Eating Disorders

The development of EDs is shaped by a complex interplay of genetic, sociocultural, and psychological factors, each uniquely contributing to the emergence and persistence of these serious mental health conditions. A study by Culbert et al. (2015) showed that the interplay of diverse biopsychosocial factors creates a significant risk for developing EDs. They further noted that the combination of psychological and environmental influences

may trigger the manifestation of genetic predispositions associated with ED risk. Even though these factors are interrelated, the following paragraphs aim to explain genetic, environmental, and personal factors separately.

The review by Barakat et al. (2023) highlights the significant hereditary contribution to EDs as evidenced by genetic studies, including research involving twins and families. For instance, Bould et al. (2015) reported that individuals with a parental history of EDs are more than twice as likely to develop these disorders. Similarly, Thornton et al. (2010) found that having a relative with an ED markedly increases the risk, with odds being 11 times higher for AN, 9.6 times higher for BN, and 2.2 times higher for BED compared to those without a family history. Furthermore, genetic susceptibility appears to be influenced by gender, with women exhibiting a greater genetic predisposition to disordered eating than men, as noted by Baker et al. (2009). From a biological perspective, Versini et al. (2010) explained this disparity by inherited variations in the estrogen receptor gene, which have been linked to an increased risk of restrictive eating patterns and the subsequent development of the restrictive subtype of AN.

Environmental factors have established links with the development of EDs. Research indicates that environments, even before birth, can contribute significantly to the emergence of EDs. For instance, the intrauterine environment can have a profound impact on the development of these disorders. Specifically, prenatal exposure to elevated levels of testosterone, cortisol, or certain substances has been associated with a heightened risk of developing EDs (Kothari et al., 2014; St-Hilaire et al., 2015). Moreover, the influence of environmental factors during childhood, particularly adverse experiences, is well established in relation to EDs. Childhood adversities, including maltreatment, have been strongly associated with the development of these disorders (Dawson et al., 2022; Emery et al., 2021; Talmon & Widom, 2022). In an observational study conducted with adolescents receiving treatment for EDs, bullying emerged as the most prevalent form of trauma experienced by patients (Hicks White et al., 2018). Additionally, Lie et al. (2021) found that individuals with EDs, particularly those with BN and BED, were significantly more likely to have experienced bullying victimization during childhood and adolescence

compared to control groups. The study also highlighted that individuals with EDs were two to three times more likely to report verbal, indirect, and digital bullying than controls, with bullying occurring more frequently prior to the onset of EDs. Furthermore, not only early life but also traumatic experiences later in life are also linked to EDs. For instance, post-traumatic stress disorder (PTSD) is frequently comorbid with EDs, as demonstrated in the study conducted by Rijkers et al. (2019), which highlights how trauma can negatively impact emotional regulation and self-esteem, thereby contributing to the development of EDs. Hence, it can be inferred that a stressful environment may serve as a substantial contributor to the emergence of disordered eating behaviors.

In addition to the impact of trauma-related environmental factors, cultural norms that enforce standardized body image, along with the beauty ideals propagated by the media, play a critical role in the development of EDs. These societal standards perpetuate unrealistic body ideals, thereby intensifying body image dissatisfaction, which is among the characteristics of EDs. This phenomenon is elucidated by Hamid et al. (2023) through the lens of Social Comparison Theory by Festinger (1954). This theory posits that individuals evaluate their personal and social worth based on comparisons with others; thus, contrasting oneself with idealized portrayals in the media engenders feelings of inadequacy and unattractiveness, ultimately precipitating disordered eating behaviors. Empirical research conducted by Rodgers et al. (2011) provides a clear connection between appearance pressures, social comparisons, and body dissatisfaction, all of which are linked to the prevalence of eating disturbances.

Furthermore, research indicates that the prevalence of EDs is notably higher in Western societies (Qian et al., 2022). In these cultures, thinness is often equated with beauty and success (Bordo, 1993); this may contribute to comparisons among individuals, driven by societal standards and media portrayals of attractiveness, which in turn can lead to the adoption of unhealthy eating habits. Branley and Covey's (2017) analysis of social media content demonstrates that users frequently encounter content promoting the "thin ideal," intensifying the pressure to conform and increasing the prevalence of unhealthy eating patterns. In addition, Singh and Padmaja (Singh & Gadiraju, 2020) underscore the

combined impact of media, peers, and family in promoting body ideals that generate dissatisfaction with one's body, subsequently contributing to the development of disordered eating habits. Moreover, Hamid et al. (2023) affirm that family, peers, and media significantly influence body image dissatisfaction, which consequently leads to eating-related issues. Thus, it can be concluded that idealized images considerably distort individuals' body perceptions, establishing a detrimental cycle of unhealthy behaviors motivated by the pursuit of societal approval.

Individuals with EDs exhibit a range of personality traits that significantly contribute to the onset and maintenance of these conditions, as outlined in the review by Barakat et al. (2023). Perfectionism, defined as setting excessively high-performance standards and engaging in overly critical self-evaluation, is a prominent trait associated with EDs, particularly AN and BN (Farstad et al., 2016). Notably, in binge-eating disorder (BED), perfectionism often manifests as frustration with an inability to adhere to rigid dietary standards, leading to binge-eating episodes (Fairburn et al., 2003). Research indicates that impulsivity, especially negative urgency—the tendency to act impulsively under emotional distress—is more common in binge/purge subtypes of EDs, especially among women (Waxman, 2009). A neuropsychological study (Lozano-Madrid et al., 2023) revealed a noteworthy finding related to this issue. Specifically, the study indicated that individuals exhibiting binge/purge subtypes demonstrate elevated levels of impulsivity when compared to healthy controls and reveal heightened impulsive tendencies relative to those diagnosed with gambling disorder. This underscores the critical role of impulsivity in the pathology of eating disorders. Compulsivity, characterized by overcontrolled and rigid behavior, is another trait common among ED patients. Adams et al. (Adams et al., 2024) found that perfectionism indirectly contributes to ED pathology through compulsive exercise, which is classified as an inappropriate compensatory behavior in ED criteria (APA, 2013). Similarly, avoidance motivation, defined as the tendency to avoid situations associated with perceived punishment, is commonly observed in individuals with EDs and often perpetuates a difficult-to-break cycle (Pinson & Frank, 2024). For instance, avoiding distressing emotions or situations by engaging in binge eating may provide temporary relief but fails to address the underlying issue. This, in turn,

reinforces maladaptive behaviors, leading to repeated cycles of avoidance and disordered eating. Further, alexithymia, or difficulty in identifying and expressing emotions, is strongly associated with emotional dysregulation and maladaptive eating behaviors, particularly in both restricting and binge/purge ED subtypes (Brown et al., 2018). Emotion regulation difficulties more broadly exacerbate ED symptoms, as individuals often resort to disordered eating as a coping mechanism to manage intense emotional distress (Prefit et al., 2019; Tilstra-Ferrell et al., 2023; Walenda et al., 2021). Similarly, Miller et al. (2022) found that affective instability was notably prevalent among ED patients.

The development of EDs arises from a complex interplay of genetic, environmental, sociocultural, and psychological factors. Genetic predispositions, combined with adverse experiences such as trauma or bullying, contribute to emotional dysregulation and maladaptive coping behaviors. Sociocultural pressures, particularly idealized body standards perpetuated by media, exacerbate body dissatisfaction and promote unhealthy eating habits. Psychological traits, including perfectionism, impulsivity, compulsivity, and emotion regulation difficulties, further sustain disordered eating behaviors. Together, these factors underscore the multifaceted nature of EDs and the need for holistic approaches to understanding and addressing their root causes.

2.2.1.4. Physical and Psychological Consequences of Eating Disorders

The adverse consequences of EDs on overall well-being are widely known and documented. A recent review on medical complications associated with Anorexia Nervosa (AN) and Bulimia Nervosa (BN) revealed that AN can affect almost every system of the body due to malnutrition and loss of weight (Westmoreland et al., 2016). The complications can be categorized into several types, including gastrointestinal, endocrine and metabolic, hematological, cardiovascular, renal, reproductive, and neurological (Dalle Grave et al., 2021; Westmoreland et al., 2016). Additionally, Binge Eating Disorder (BED), similar to AN, is associated with musculoskeletal problems and is closely linked to being overweight or obese, as well as related complications such as high cholesterol, high blood pressure, diabetes, heart disease, and cancer (Wassenaar et al., 2019). It has

also been found that EDs can contribute to the onset of frontotemporal dementia (Bello et al., 2020).

Individuals who suffer from eating disorders (EDs) are also at a high risk of comorbidity of other mental health problems. For instance, comorbidity with post-traumatic stress disorder (PTSD) ranges from 9% to 24%, according to a study by Rijkers et al. (2019). EDs are often associated with personality disorders, specifically obsessive-compulsive, avoidant, and borderline personality disorders (Martinussen et al., 2016). Substance use disorders are also prevalent among individuals with EDs (Gadalla & Piran, 2007). Based on the data from a clinical database, a study found that around 53% of individuals with EDs also experience anxiety, and 43% have depression (Ulfvebrand et al., 2015). Recent studies have shown that eating disorders (EDs) are often linked to mood disorders, specifically depressive disorders. Patients with EDs have a higher rate of mood disorders compared to those in the general population, with an 80% global prevalence rate for each ED group (Godart et al., 2015).

Unfortunately, these comorbidities exacerbate the symptoms of EDs and negatively affect the treatment outcome (Martinussen et al., 2016). Eventually, both somatic and psychological consequences of EDs increases the mortality levels (Arcelus et al., 2011). Even with advanced treatment methods, individuals who have undergone inpatient treatment for AN still face more than five times the mortality risk. In case of BN and AN patients who receive treatment outside of the hospital have a lower risk, but it's still twice as much than community controls (Van Hoeken & Hoek, 2020).

Researchers have found that the prevalence ratio of EDs can be misleading because certain groups, such as males, those with higher weight, racial/ethnic minorities, and socioeconomically disadvantaged groups, are less likely to seek treatment (Sonneville & Lipson, 2018). Additionally, treatment outcomes are highly influenced by various factors, such as low weight, difficulty in regulating emotions, and childhood traumas, all of which have a negative impact on the effectiveness of treatment (Gorrell et al., 2023). In conclusion, eating disorders are prevalent and their consequences are detrimental, but a

significant portion of people do not seek treatment. Therefore, it is crucial to understand the variables that affect treatment outcomes in order to provide better care and reach more individuals with EDs.

2.2.2. Childhood Maltreatment

It is well established that childhood maltreatment (CM) is a pervasive global issue that has long-lasting effects on individuals exposed to it. CM refers to any form of abusive or neglectful acts that result in potential or actual harm or injury to an individual under the age of 18 (WHO, 2022). It may involve the forms of physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect (Bernstein et al., 2003), denial of basic needs (APA, 2018), overprotection-overcontrol parenting (Şar et al., 2021), and exploitation that results in harming child's physical or mental health, survival, development, or dignity in the course of a relationship of responsibility, trust or power (WHO, 2022).

The literature often conceptualizes childhood maltreatment under the umbrella of a broader concept of adverse childhood experiences (ACEs) (Massullo et al., 2023). According to WHO (2023), childhood maltreatment is a part of it and frequently occurs alongside other forms of ACEs, such as household dysfunction, which may include parental violence, instability due to parental separation, exposure to violence within the household, having a family member with substance abuse issues, mental health problems, or suicidal thoughts or actions. To clarify the scope of this research, it can be helpful to define the types of maltreatment that are considered CM.

Childhood physical abuse (CPA) is non-accidental injury to a child, regardless of the intention, inflicted by a parent, caregiver, or other individual responsible for the child. It can take many forms, ranging from minor bruises to severe fractures or even death, and can result from hitting, burning, choking, or any other method (APA, 2013).

Childhood emotional abuse (CEA) refers to intentional verbal or symbolic actions carried out by a parent, caregiver, or any person entrusted with the responsibility of a child, which can cause significant psychological harm to the child. This form of abuse can take various forms such as berating, disparaging, humiliating, threatening, as well as harming or abandoning people or things that the child cares about (APA, 2013).

Childhood sexual abuse (CSA) is any sexual activity involving a child intended to please a parent, caregiver, or other responsible adult. This includes touching a child inappropriately, sexual acts like rape or incest, and forcing or pressuring a child to take part in sexual activities for someone else's satisfaction, even without physical contact between the child and the abuser (APA, 2013).

Childhood physical neglect (CPN) is caregivers' intentional failure to provide a child with essential needs such as food, water, shelter, clothing, and medical care. It is characterized by insufficient general care and healthcare, which can result in significant developmental disruptions, including conditions like psychosocial dwarfism and short stature, and, in extreme cases, death due to starvation (Marc & Hanafy, 2015; Schreier et al., 2020).

Childhood emotional neglect (CEN) is characterized by the persistent failure of parents or caregivers to adequately address and meet a child's emotional and developmental needs. This form of neglect is closely associated with the quality and nature of the relationship between the child and their caregivers, wherein the child's emotional and developmental requirements are consistently overlooked or disregarded (Ban & Oh, 2016; Dong et al., 2023; Ylitervo et al., 2023).

Parental overprotection or overcontrol (OP-OC) is a style of parenting that involves excessive sheltering (Moussa Rogers & McKinney, 2019), monitoring, helping, and intrusiveness (Dreher et al., 2014; Otani et al., 2013) while lacking warmth (Spokas & Heimberg, 2009). Brain studies indicate that parental overcontrol should be regarded and studied as a form of childhood maltreatment because, similar to other well-established

forms of maltreatment, it affects brain functionality and neural networking, potentially resulting in psychopathology (Carbone et al., 2024).

Childhood maltreatment is prevalent worldwide. The data presented by WHO (2022) estimates that globally, 75% of children aged between 2 and 4 experience physical or psychological violence from their caregivers. 20% of women and nearly 8% of men reported they had been sexually abused as a child. Approximately 120 million girls and young women below the age of 20 have experienced some type of coerced sexual contact. The data from the US shows that 64% of adults reported experiencing at least one ACE, and 17.3% reported experiencing at least four types of ACEs (Centers for Disease Control and Prevention (CDC), 2023). A systematic review run by Moody et al. (2018) is significant in shedding light on global maltreatment prevalence and providing valuable insights into various forms of maltreatment worldwide. The review revealed varying ratios of child sexual abuse victimization among girls, ranging from 9.0% in Asia to 28.8% in Australia. In contrast, for boys, the ratio ranged from 6.1% in Australia to 26.5% in South America. Physical abuse showed the highest prevalence in Africa, with rates of 60.2% for boys and 50.8% for girls, followed closely by South America, with ratios of 57.3% among boys and 59% among girls. In terms of emotional abuse, Europe exhibited the lowest rates, at 6.2% for boys and 12.9% for girls. In Africa, emotional abuse rates were almost identical for boys and girls, affecting approximately 30% of participants during childhood. Conversely, in Asia, boys were more likely to report emotional abuse than girls, with rates of 33.2% and 26.9% respectively. Regarding child neglect, North America showed a significant gender disparity, with rates of 40.5% among girls and 16.6% among boys. Australia had the highest neglect rates, at 75.5% for boys and 65% for girls, followed by South America, with nearly equal ratios among boys and girls (54.8% and 56.7% respectively).

The prevalence of CM in Turkiye has been highlighted by various studies, shedding light on its widespread occurrence and associated factors. Ustuner-Top and Cam (2021) examined 626 university students and discovered that 43.5% had encountered at least one type of CM. Specifically, emotional abuse was the most prevalent at 40.3%, followed by

physical abuse (31.8%), sexual abuse (30.4%), emotional neglect (30.0%), and physical neglect (44.7%). Another study involving 2257 university students found lower prevalence rates, with 21.1% reporting physical abuse, 7.9% sexual abuse, 9.8% emotional abuse, 8.8% emotional neglect, and 5.7% physical neglect (Ulukol et al., 2016). A broader perspective is provided by Sofuoğlu et al. (2016), who conducted a large-scale study on 2608 children with their parents and confirmed that CM is pervasive across Turkiye. This study highlighted discrepancies in parental reporting, indicating an underestimation of maltreatment incidents. Among the findings, 16-year-old boys reported emotional abuse most frequently, whereas 13-year-old boys reported physical abuse as the most common form of maltreatment.

These studies also underscore the critical role of socioeconomic factors in shaping the prevalence and reporting of CM. Sofuoğlu et al. (2016) identified a significant negative correlation between child abuse and parents' economic conditions, suggesting that lower economic stability increases the likelihood of maltreatment. Similarly, the father's educational background was negatively associated with engaging in acts of psychological abuse, highlighting how socioeconomic and educational factors can influence parenting behaviors. Furthermore, Şar et al. (2021) undermine the prevalence of parental OP-OC in Turkiye and its adverse impacts on individuals' lives. Collectively, these findings reveal the interplay of socioeconomic, cultural, and familial factors in the prevalence and dynamics of childhood maltreatment in Turkiye.

Today, it is widely recognized that encountering physical, sexual, and emotional abuse or neglect prior to reaching the age of 18 or being raised in an environment characterized by extremely overprotective and controlling parental figures, can have detrimental effects on an individual's physical as well as psychological well-being (Cay et al., 2022; Insana et al., 2016; Watts-English et al., 2006). It was shown consistently that these experiences can act as precursors to a wide array of psychological disorders (Nelson et al., 2017). Consequently, scholars have adopted an approach to examining childhood maltreatment as a significant transdiagnostic factor. They argue that these experiences exhibit

transdiagnostic characteristics as they increase the likelihood of developing distinct psychological disorders and physiological problems (Jaffee, 2017; McLaughlin, 2016).

Starting with physiological consequences, studies demonstrated that there are associations between childhood adversities and vulnerability to developing medical health problems such as liver injury (Clark et al., 2010), respiratory or lung disease (Goodwin & Wamboldt, 2012), mortality (Chen et al., 2016), cardiovascular disease (Caceres et al., 2022), and obesity (Kobulsky et al., 2023; Schroeder et al., 2021). Besides, the impact of these adverse childhood experiences can lead to negative outcomes that can damage health across the lifespan. For example, childhood maltreatment is a significant risk factor for alcohol misuse (Clark et al., 2010), marijuana addiction (Proctor et al., 2017), and tobacco use (Mills et al., 2014).

As stated previously, experiencing childhood maltreatment substantially increases the likelihood of developing psychiatric disorders. A meta-analysis (Nelson et al., 2017) presented that individuals with a history of childhood maltreatment were almost 3 times more likely to develop depression in adulthood, with an earlier onset and higher severity in symptoms. A meta-analysis examined the effects of childhood maltreatment on the severity of bipolar disorder symptoms (Agnew-Blais & Danese, 2016). The study found that individuals who experienced maltreatment during childhood and have bipolar disorder tend to have more severe mania, depression, and psychosis symptoms. They also have a higher risk of rapid cycling, more frequent manic and depressive episodes, and an increased likelihood of comorbid post-traumatic stress disorder, anxiety disorders, and substance use disorders. The studies also show that childhood maltreatment relates to problematic eating behaviors, eating disorder symptomatology, and maladaptive eating attitudes (Emery et al., 2021; Mares et al., 2023; Musetti et al., 2023; Solmi, Radua, et al., 2021). Moreover, childhood abuse and bullying emerged as strong predictors of non-suicidal self-injury behaviors (Wang et al., 2024), also different forms of childhood maltreatment indicating an increased risk for suicide (Behr Gomes Jardim et al., 2018).

Consequently, it is quite clear that CM is prevalent and affects millions of children worldwide and has long-lasting effects on their physical, mental, and emotional well-being. Therefore, it is important to address maltreatment experiences and study it from a transdiagnostic perspective in order to understand its underlying adverse impacts on individuals' lives.

2.2.3. Emotion Regulation

Emotion regulation has been a focal point of research in affective science for several decades. James Gross (1999), a prominent researcher in the field, defined emotion regulation as the processes by which individuals manage and modulate their emotional responses and subjective experience of emotions. These processes can be either automatic or controlled, intending to increase or decrease the intensity, duration, physiological state, or form of emotions to achieve one's goal by relating to the emotion (Kok, 2017). According to Thompson (1994), emotion regulation refers to all internal or external features that can help change emotional reactions. This includes biological, social, behavioral, and both conscious and unconscious cognitive processes that involve a diverse range of strategies. These strategies include self-regulation of emotions or regulation by others and can target the emotion itself or its underlying components.

The ability to functionally regulate emotions and properly deal with the emotions has an important role in one’s wellbeing. It can be concluded so, as the contrary relation is well established by a significant body of literature. More specifically, literature demonstrated that dysfunctional emotion regulation strategies and difficulty in emotion regulation or limited awareness regarding one’s emotions are connected with almost all types of psychological disorders (Aldao et al., 2010; Kimhy et al., 2016) and accountable for comorbidity between various psychopathologies (McLaughlin et al., 2014; Messman-Moore & Bhuptani, 2017). This situation makes emotion regulation a significant transdiagnostic mechanism for understanding various psychopathologies at a deeper level (McLaughlin et al., 2020; Trompeter et al., 2021).

While exploring psychological disorders, considering emotion regulation strategies used by individuals can provide insights into the course of the pathologies. For example, a recent meta-analysis found that acceptance, mindfulness, and reappraisal strategies are negatively, and avoidance, distraction, rumination, and suppression strategies are positively related to borderline personality disorder (Bud et al., 2023). It is important to explore this relationship because the use of various strategies may influence the development or exacerbation of symptoms. In line with this, scholars broadly classify emotion regulation strategies as adaptive strategies and maladaptive strategies based on their relation to psychological disorders (Aldao et al., 2010, 2014; Aldao & Nolen-Hoeksema, 2012; Gross, 2015). To point out its significance, this study investigates the role of adaptive and maladaptive cognitive emotion regulation strategies, specifically.

2.2.3.1. Cognitive Emotion Regulation Strategies

Garnefski et al. (2001) have highlighted that the concept of emotion regulation is useful, but the process itself is quite broad and complex. Therefore, it becomes challenging to focus on all aspects of it empirically at once. To overcome this issue, they recommended focusing on one aspect at a time, which could provide a deeper understanding. As a result, Garnefski et al. (2001) developed the cognitive theory of emotion regulation, which specifically examines the self-regulatory, conscious, and cognitive aspects of emotion regulation.

Cognitive emotion regulation is a cognitive way of dealing with emotionally arousing information (Garnefski et al., 2001; Thompson, 1991). The idea is that individuals can use cognitive processes to manage and regulate their emotions, preventing becoming overwhelmed in situations that can arouse emotions, such as stressful events. Garnefski (2001) defined nine strategies universally individuals use to cope with negative life events, which are as follows:

> ***Self-blame*** is characterized by thoughts that an individual tends to attribute negative events or outcomes to their actions or characteristics. ***Blaming others*** refers to thoughts of blaming other individuals for the experienced negative situation. ***Acceptance*** refers to an individual's thoughts of accepting what they have experienced and resigning themselves to what has occurred. ***Refocusing***

on planning involves thinking about how to handle negative situations and take necessary steps. ***Positive refocusing*** involves redirecting your thoughts towards positive and enjoyable things instead of thinking about what actually has happened. ***Rumination***, or in other words, *focus on thought*, refers to constant thoughts regarding the feelings and thoughts related to the negative experience they have encountered. ***Positive reappraisal*** refers to inferring a positive meaning from the negative situation and considering these experiences as opportunities for personal growth. ***Putting into perspective*** is comparing the situation with other events to classify its magnitude or diminishing the significance or seriousness of the negative event. ***Catastrophizing*** refers to magnifying the fear or terror of a particular experience in one's thoughts.

Even though the ability to use cognitive emotion regulation strategies is universal among humans, individual differences impact the use of different strategies. Studies have demonstrated that personal differences such as age (Garnefski & Kraaij, 2006), education level (Balzarotti et al., 2016), gender (Zlomke & Hahn, 2010), genetics, and environment (Milovanović et al., 2018) can be related to strategy choice. This is a significant issue because some of the cognitive emotion regulation strategies described above are considered more adaptive than others. For example, *acceptance*, *positive refocusing*, *refocusing on planning*, *positive reappraisal*, and *putting into perspective* are generally considered adaptive strategies; on the other hand, *self-blame*, *blaming others*, *rumination*, and *catastrophizing* are often seen as less adaptive (Garnefski et al., 2001; Jermann et al., 2006).

It's important to note that the relationship between acceptance strategies and psychological complications, including depression and anxiety, is complex and multifaceted. Although often perceived as an adaptive strategy, acceptance can yield both beneficial and detrimental outcomes depending on the context and the specific type of acceptance employed. The theoretical framework surrounding acceptance (Carver et al., 1989) is supported by empirical findings (Overall, 2019; Sugiura et al., 2023; Wang et al., 2021), which suggest that acceptance is generally viewed as a more adaptive strategy. Furthermore, acceptance demonstrates therapeutic efficacy in settings such as Acceptance and Commitment Therapy (ACT) (Hayes et al., 2006), which has gained prominence in the field due to its impactful outcomes (Hulbert-Williams & Hulbert-Williams, 2022).

Conversely, certain forms of acceptance are associated with diminished well-being and heightened psychological complications, such as depression and anxiety (Martin &

Dahlen, 2005). This encompasses forms of passive acceptance, wherein individuals acknowledge their negative emotions or situations without addressing the underlying issues, thereby perpetuating a cycle of avoidance that exacerbates psychological distress (Pretorius et al., 2010). Additionally, resigned acceptance is characterized by a sense of helplessness, where individuals acquiesce to their conditions without actively employing coping strategies or seeking improvement, was found to be related to exacerbated feelings of distress and diminished quality of life (Duncanson et al., 2022; van Beugen et al., 2017).

When considering the definition of the acceptance subscale as presented by Garnefski and Kraaij (2007), it appears to assess a maladaptive form of acceptance. Similarly, as Tuna and Bozo (2012), who adapted the scale into Turkish, point out that the adaptive/maladaptive categorization of the strategies of CERQ should be reconsidered, as the acceptance subscale shows positive relations with various psychological complications such as depression, anxiety, negative self-concept, hostility and negative associations with self efficacy. Therefore, it is crucial to understand that the relationship between acceptance strategies and psychological complications is not straightforward. This is why it is essential to consider that the CERQ might not be assessing the positive acceptance that elicits adaptive outcomes.

Before proceeding, it is important to clarify that in this study, rather than using the terms "less adaptive" or "more adaptive" for CERS, the titles adaptive and maladaptive will be utilized. Here, the term "maladaptive" was preferred to signify less adaptive strategies instead of using "less adaptive" to avoid confusion and to be more precise. While all strategies can be considered adaptive to some extent, some are more adaptive than others, as mentioned above. The use of "maladaptive" in this context does not necessarily imply that these strategies are inherently maladaptive but rather suggests that they are not as effective and adaptive as the more adaptive ones. Furthermore, these less adaptive strategies are found to be more connected to psychological issues. Therefore, for the purpose of clarity and precision, the term "maladaptive" was utilized to distinguish these less adaptive strategies from the more adaptive ones.

Coming back to CERS, research suggests that the strategies used to regulate emotions can affect an individual's psychological distress in response to a life stressor (Garnefski & Kraaij, 2006). This means that using maladaptive strategies might lead to detrimental effects on psychological well-being. According to a study conducted with a non-clinical sample, maladaptive CERS such as rumination, catastrophizing, and self-blame were found to be positively associated with depressive symptoms, while an adaptive CERS like positive reappraisal was negatively related to these symptoms (Jermann et al., 2006). Another study found that maladaptive CERS strategies were connected to higher depressive symptoms and anxiety (Garnefski & Kraaij, 2007). Similarly, Duru and Balkıs (2024) discovered that the relationship between negative life events and psychological distress is stronger when maladaptive CERS were used frequently, and adaptive CERS were used less.

Research indicates that individuals' strategies for regulating their emotions can have a profound impact on their psychological well-being, particularly in difficult circumstances. In this context, CERS have an undeniable role in psychological well-being (Garnefski & Kraaij, 2007). Nevertheless, despite abundant research highlighting the challenges associated with emotion regulation and its detrimental effects on psychological health, the role of CERS remains understudied in relation to various psychopathologies. While the majority of studies have focused on anxiety, stress, and depression, recognizing the transdiagnostic nature of emotion regulation necessitates further investigation into the associations of CERS with various psychological disorders to yield valuable insights.

2.3. Emotion Regulation and Eating Disorders

A significant number of studies that examine the relationship between emotion regulation (ER) and eating disorders (EDs), consistently finding that individuals with EDs experience greater difficulties in ER and frequently rely on maladaptive ER strategies compared to controls (Brockmeyer et al., 2014; Prefit et al., 2019; Puttevils et al., 2021; Svaldi et al., 2012). These difficulties in emotion regulation and the reliance on maladaptive strategies play a crucial role in the development and exacerbation of ED symptoms in clinical and

nonclinical populations (Haynos & Fruzzetti, 2011). When individuals struggle to regulate their emotions adaptively, they may adopt maladaptive behavioral strategies, such as eating restrictions, binging, or purging, as a means to cope with their emotional distress (Fairburn et al., 2003). This pattern of behavior underscores a critical connection between ER difficulties and EDs.

Previous studies demonstrated these difficulties are associated with the development of specific EDs, including anorexia nervosa (AN) (Brockmeyer et al., 2012; Harrison et al., 2009), bulimia nervosa (BN) (Harrison et al., 2010; Kessler et al., 2006), and binge eating disorder (BED) (Carano et al., 2006; Monell et al., 2018; Zeeck et al., 2011). By highlighting these connections, it becomes clear how the interplay between emotional struggles and maladaptive coping mechanisms contributes to the onset and persistence of various EDs.

Scholars have proposed that individuals overwhelmed by their emotions and unable to regulate them may exhibit ED symptomatology as a maladaptive mechanism for self-regulation. For instance, rather than dealing adaptively with their emotions, restrictive eating may serve to suppress overwhelming emotions (Haynos et al., 2018; Lafrance Robinson et al., 2014), while overcontrol of food intake may temporarily alleviate feelings of embarrassment, shame, or guilt (Corstorphine, 2006; Schmidt & Treasure, 2006). Alternatively, behaviors like binge eating, excessive exercise, or vomiting may provide a way to escape persistent negative thoughts or feelings (Arbuthnott et al., 2015; Nolen-Hoeksema et al., 2007; Overton et al., 2005). Cognitive processes such as rumination and catastrophizing, which are prevalent in EDs, further exacerbate symptoms like the drive to be thin, body overvaluation, purging, and binging (Verschueren et al., 2021). Rumination, in particular, has been linked to higher rates of binging (Smith et al., 2019) and greater weight concerns accompanied by eating restraint (Dworschak et al., 2023). Similarly, a systematic review conducted by Walenda et al. (2021) revealed that catastrophizing is highly prevalent among individuals with BED.

Interestingly, EDs are not only connected with dysregulation or maladaptive emotion regulation strategies for negative emotions but also positive emotions. Selby et al. (2019) stated that difficulties in regulating positive emotions could be linked to binge eating, symptom relapses, and challenges in treatment. These findings underscore the complexity of ER difficulties in EDs, encompassing both maladaptive responses to negative and positive emotional states.

While the literature highlights the significant role of maladaptive ER strategies—such as rumination and thought suppression—in the development and maintenance of EDs, research has primarily focused on these maladaptive strategies, with less attention given to adaptive ER strategies. Among the few studies addressing this gap, Walenda et al. (2021) found that cognitive reappraisal, an adaptive ER strategy, is used less frequently by individuals with BED compared to maladaptive strategies. Similarly, Aldao and Nolen-Hoeksema (2010) found that maladaptive strategies are more strongly associated with ED pathology than adaptive strategies, such as reappraisal and problem-solving. Nevertheless, there exists a paucity of studies investigating the potential protective effects of adaptive ER strategies against the onset of eating disorder symptoms remain limited. Future research should address this gap by investigating both maladaptive and adaptive ER strategies to enhance the understanding of ER dynamics in EDs.

2.4. Emotion Regulation and Childhood Maltreatment

The development of emotion regulation processes occurs during the initial two decades of life (Casey et al., 1997). This can explain why childhood maltreatment, which comprises the life stage before the age of 18, is found as related to impairments in emotion-related difficulties. Existing literature indicates that challenges in emotion regulation are linked to early traumatic experiences and play a mediating role in the manifestation of various forms of psychopathology (Heleniak et al., 2016; Kim-Spoon et al., 2013; Milojevich et al., 2019). Moreover, emotion processing with adverse life events is regarded as possessing transdiagnostic features, indicating its potential role as an underlying factor in multiple psychopathologies (Fairburn et al., 2003; McLaughlin et al., 2020).

A meta-analysis, conducted by Gruhn and Compas (2020), focusing on the impact of maltreatment on coping strategies and emotion regulation among children and adolescents, demonstrated a significant positive relationship between maltreatment and emotion dysregulation. The study suggests that exposure to maltreatment at an early age may disrupt emotion regulation processes, leading to inappropriate use of coping strategies even in non-maltreating situations.

It is important to note that while emotion regulation and coping strategies can be helpful in certain situations, their improper or extensive use can be dysfunctional and maladaptive. For instance, self-blame can be adaptive when it elicits moral emotions such as guilt and leads individuals to apologize for their misbehaving (Tangney et al., 2007). However, when individuals blame themselves for circumstances they are not responsible for, it can have detrimental effects on their well-being. A study conducted with sexually assaulted African American women exemplify this by showing that women who blame themselves for what happened to them often exhibit depressive symptoms, which later lead them to suicidal ideation (Sigurvinsdottir et al., 2020). This underscores that emotion regulation strategies, including self-blame, can be employed adaptively to enhance interpersonal relationships, but their misuse can lead to suffering.

Several studies focusing on the impacts of CM on the brain's functionality showed that CM alters the large-scale brain networks related to emotion regulation (Cassiers et al., 2018; Farina & Imperatori, 2024; Teicher et al., 2016). A behavioral and neuropsychological study (Marusak et al., 2015) utilized fMRI to examine a total of 30 children and adolescents, with 14 of them being trauma-exposed and 16 selected as age, sex, and IQ-matched comparison participants. The study revealed that young individuals with a history of trauma experienced challenges in regulating emotional conflict due to certain brain areas failing to facilitate proper emotion regulation. More specifically, it is about failure to decrease activity in the dorsolateral prefrontal cortex and engage the amygdala-pregenual cingulate inhibitory circuitry. These individuals also demonstrated heightened conflict-related amygdala reactivity, which is linked to lower levels of

sensitivity to rewards. In brief, the brain activity of youth exposed to trauma differs in their ability to regulate emotions compared to their peers.

Hence, studying the relationship between childhood maltreatment and emotion regulation is essential for understanding the development of various psychological disorders. It is worth noting that there is a shortage of literature specifically focusing on cognitive emotion regulation strategies. Examining both adaptive and maladaptive cognitive emotion regulation strategies could lead to new insights into relevant variables.

2.5. The Relationship between Childhood Maltreatment and Eating Disorders

The connections between childhood maltreatment and mental disorders associated with eating behaviors are well established (eg., Brewerton, 2007; Caslini et al., 2016; Molendijk et al., 2017; Solmi, Radua, et al., 2021; Trottier & MacDonald, 2017). A study involving 432 adolescents revealed that individuals who encountered four or more adverse childhood experiences (ACEs) were 5.7 times more inclined to fall into the category of high risk for eating disorders, in contrast to those who reported no ACEs (Kovács-Tóth et al., 2022). Another study conducted by Emery et al. (2021) showed that people who had experienced any type of childhood maltreatment were 60% more likely to develop chronic dieting and overeating. Furthermore, they indicated that each type of childhood maltreatment was linked to at least one form of disordered eating behavior or attitude. Emotional neglect was particularly strongly associated with disordered eating behaviors and attitudes. Additionally, a study found that poly-victimization is related to higher body mass index (Christie & Matthews, 2019). Another study conducted among students demonstrated physical abuse, emotional abuse, emotional neglect, and physical neglect connected to ED symptomatology (Moulton et al., 2015). A systematic review showed that CMs are related to more severe ED symptoms and poorer treatment outcomes (Rossi et al., 2024). Overall, the literature shows a consistent relationship between childhood maltreatment and eating disorder symptomatology. The findings from the literature underscores the established associations between different types of childhood maltreatment and the development of eating disorders. Thus, the relationship between

different types of CMs, namely abuse and neglect, and eating disorders is reviewed in the following.

2.5.1. Childhood Abuse and Eating Disorders

The impact of childhood abuse on the development of eating disorders has been the subject of extensive research. All forms of abuse, namely physical, emotional, and sexual abuse, have been studied in relation to their influence on the onset, severity, and course of eating disorders in later life. Several notable studies have demonstrated significant associations between childhood abuse and developing eating disorders. For instance, childhood physical abuse (CPA) was recognized as a significant indicator of eating disorders (Kovács-Tóth et al., 2022). A meta-analysis conducted by Caslini et al. (2016) revealed a substantial correlation between CPA and the development of AN, BN, and BED. Similarly, Afifi et al. (2017) identified strong connections between CPA and various eating disorders, and Borg et al. (2022) found that CPA impacts the severity of disordered eating behaviors. Moreover, longitudinal studies, such as the one conducted by Talmon & Widom (2022), found that individuals who reported CPA and childhood sexual abuse (CSA) were more likely to exhibit symptoms of AN.

The relationship between CSA and EDs is characterized by a body of literature that presents some conflicting findings. For instance, research conducted by Talmon and Widom (2022) has identified significant associations between CSA and AN. A longitudinal study focusing on sexual abuse found that female adolescents who had experienced sexual abuse in childhood showed more severe bulimia nervosa symptoms compared to their non-abused peers (Li et al., 2019). Similarly, early research by Smolak and Murnen (2002) found a small but significant relationship between childhood sexual abuse and eating disorders. Additionally, Chen et al. (2010) reported strong associations between sexual abuse, especially a history of rape, and eating disorders. Conversely, other studies, such as those by Burns et al. (2012) and Li et al. (2024), found no direct relationship between CSA and EDs. These studies attribute their results to several factors, including the co-occurrence of different forms of abuse (e.g., CEA), the limitations

inherent in assessment tools that focus primarily on the frequency of abuse rather than its severity, and the phenomenon of underreporting, which often arises due to individuals' hesitance or inability to recognize and label their experiences as abusive.

There are studies demonstrating the relationship between CSA and BED. A study by Grilo and Masheb (2001) revealed that 83% of BED patients reported at least one type of childhood trauma, and 30% of them reported sexual abuse. A recent study supported this finding and found a link between CSA and BED, which is mediated by body shame (O'Loghlen et al., 2023). Despite some contradictory findings, it can be suggested that childhood sexual abuse is related to the development of eating disorders.

Numerous studies have investigated the correlation between childhood emotional abuse (CEA) and various disordered eating patterns. Vajda and Láng (2014) found that emotional abuse had the highest prevalence in individuals with bulimia nervosa (BN), followed by those with AN. Recent research consistently indicates that CEA is a significant predictor of BED, along with physical abuse and emotional neglect (Friedman et al., 2023; Grilo & Masheb, 2001). A meta-analysis by Caslini et al. (2016) revealed that CEA was explicitly linked to BN and BED. Additionally, Akgöz Aktaş et al. (2023) demonstrated that CEA is related to developing disordered eating patterns and self-criticism and has a mediating role in this relationship. Similarly, Gioia et al. (2022) concluded that emotional abuse can directly and indirectly predict disordered eating behaviors. Furthermore, Borg et al. (2022) suggested that emotional abuse can influence the severity of eating disorders. Thus, it can be inferred that CEA is a substantial predictor of eating disorders.

Childhood abuse is not only connected with developing EDs but also worsening the symptoms, increasing the likelihood of relapses, and comorbidity with other psychological issues. A longitudinal study demonstrated that ED patients who reported sexual and/or physical abuse showed higher impulsivity, comorbidity with other psychiatric disorders, and lower recovery with higher diagnostic crossover (Castellini et al., 2018). In conclusion, there is a significant impact of childhood abuse on the

development and severity of eating disorders in later life. Multiple studies have shown significant associations between different forms of childhood abuse and various types of eating disorders. While some conflicting findings exist, the overall body of research suggests that childhood abuse plays a crucial role in the etiology of eating disorders.

2.5.2. Childhood Neglect and Eating Disorders

Neglect, both emotional and physical, has been recognized as highly prevalent worldwide (Moody et al., 2018). However, its significance in relation to eating disorders has not been sufficiently explored, as the primary emphasis remains on abuse. (Talmon & Widom, 2022). The limited literature on the relationship between neglect and disordered eating behaviors highlights the critical role of neglect in developing such behavioral patterns. For example, a study conducted with ED patients revealed that neglectful parenting is related explicitly to bulimia, the desire to be thin, and body dissatisfaction (Jáuregui Lobera et al., 2011).

Research on the relationship between childhood emotional neglect (CEN) and the development of eating disorders has produced significant findings in terms of explaining the relationship. Emery et al. (2021) suggested that particularly CEN bears considerable responsibility for being a risk factor for developing eating disorders for both women and men. Similarly, according to Gioia et al. (2022), emotional maltreatment, both abuse and neglect, strongly predicts disordered eating. A study found that it is connected with binge eating with the mediating role of internal shame and psychological distress (O'Loghlen et al., 2023). Additionally, Ernst et al. (2019) found that, specifically, CEN is associated with severe obesity, and it was suggested that CEN might be associated with higher vulnerability toward EDs among women.

As mentioned previously, the literature on neglect is comparatively limited, and this holds true for childhood physical neglect (CPN). Yet, despite the limited research available, emerging evidence consistently suggests that CPN is linked to the development of eating disorders (Afifi et al., 2017; Gioia et al., 2022; Kimber et al., 2020; Kong & Bernstein,

2009). The prevalence of CPN appears to be significant among individuals with eating disorders. A study by Pignatelli et al. (2017) revealed that 45.4% of those with eating disorders reported CPN, indicating a potential association between childhood physical neglect and the development of eating disorders. Furthermore, CPN was found to increase the risk of underweight in men (Ernst et al., 2019).

Various mediators have been proposed to explain the relationship between CPN and EDs. For instance, Khalil et al. (2020) discovered a connection between CPN and the development or exacerbation of eating disorders through food addiction. Similarly, a study by Minnich et al. (2017) identified a positive association between physical neglect and disordered eating patterns, with alexithymia playing a mediating role between them.

In short, CEN and CPN have been linked to disordered eating behaviors. Although there is limited literature on this topic, the findings emphasize the need for more research to understand better and address the relationship between neglect and eating disorders.

2.5.3. Overprotective-Overcontrol Parenting and Eating Disorders

The literature indicates that parental overprotection and overcontrol (OP-OC) can have significant adverse effects on individuals' mental health (Otani et al., 2013; Spokas & Heimberg, 2009). Recent research suggests that there are notable associations between parental OP-OC and the development of disordered eating attitudes or behaviors. For instance, Gruber et al. (2020) conducted a study comparing a clinical sample diagnosed with either anorexia nervosa (AN) or bulimia nervosa (BN) with healthy controls in terms of the impact of perceived parenting style on dieting attitudes. The study found that adolescent and young adult women with BN reported experiencing more overcontrolled and overprotective parenting style, particularly from their mothers. This suggests that females who perceived an OP-OC type of maternal parenting were more susceptible to developing eating disorders. Similarly, Iqbal et al. (2023) found a similar relationship among college students, where mothers' overprotection was linked to eating problems, and emotion dysregulation was found to mediate this relationship. On the other hand,

Craba et al. (2023) suggested potential associations between paternal overprotection and AN and BN. Consistent with these findings, a review by Usmani et al. (2022) found that parental OP-OC significantly increased the risk of developing eating disorders. Additionally, the parental OP-OC style was associated with unhealthy weight control behaviors (Hampshire et al., 2022) and emotional eating (Johnson, 2018). Similarly, early research by Furnham and Adam-Saib (2001) did not find a direct relationship with eating disorders, but it did find that parental overprotection is positively associated with unhealthy eating attitudes.

Even though the existing findings consistently indicate that parental OP-OC is a risk factor for developing eating disorders, the current body of literature is limited in terms of showing a clear picture to demonstrate the relationship between eating disorders and parental overprotection and overcontrol. In fact, even though parental OP-OC is prevalent in Turkiye (Şar et al., 2021), to our knowledge, the relationship between parental OP-OC and its impact on eating disorders hasn't been studied in the Turkish population. This situation reveals the need to examine their relationship.

2.6. The Role of Cognitive Emotion Regulation Strategies in the Relationship between Childhood Maltreatment and Eating Disorders

Extensive research has been conducted on the complex interplay between CMs and EDs, with numerous studies pointing to the mediating role of emotion-related processes in this relationship. Emotion regulation difficulties, or in other words, dysregulation of emotions, were suggested to have a mediating role in the ED and CM relationship (Burns et al., 2012; Ghanei et al., 2020; Moulton et al., 2015; Racine & Wildes, 2015). A recent systematic review demonstrated that emotion regulation difficulty is a significant mediator between CMs and EDs (Rabito-Alcón et al., 2021). The review found that individuals with a history of CM often develop emotional dysregulation, which acts as a maladaptive coping mechanism for managing distress arising from traumatic experiences. This emotional dysregulation, in turn, fosters behaviors characteristic of EDs, such as restrictive eating, binge eating, or purging.

There are studies focusing on the role of emotion regulation on the relationship between specific types of maltreatment and EDs. For example, a study (Vajda & Láng, 2014) comparing healthy individuals and patients with eating disorders found significant differences in terms of having a history of emotional abuse and neglect, as well as challenges in emotion regulation. They identified emotional neglect and abuse as significant indicators for eating disorders, with emotion regulation difficulties potentially mediating this relationship. Another study with 1254 female university students found that childhood emotional abuse (CEA) significantly predicted ED symptoms, with emotion dysregulation partially mediating the relationship (Burns et al., 2012). Similarly, another study focusing on AN symptoms found that difficulty in emotion regulation significantly mediates the relationship between CEA and AN symptomatology regardless of its subtypes (Racine & Wildes, 2015). Another study found that CSA and CEA are significantly related to ED symptomatology via lack of emotional clarity, which is an emotion regulation difficulty (Tilstra-Ferrell et al., 2023). The influence of OP-OC type parenting in developing eating disorders was also examined. Iqbal et al. (2023) showed that mother overprotection is positively related to the dysregulation of emotions and the development of disordered eating. Furthermore, it was revealed that emotion dysregulation played a significant mediating role in this relationship.

The mediating relationship was also examined in treatment efficacy. For instance, a longitudinal study (Cassioli et al., 2022) that investigated the interplay of EDs, CMs, and emotion regulation found that patients who had greater difficulty with emotion regulation showed less improvement in their overall ED scores. Additionally, higher CM scores were linked to lower effectiveness of ED treatments, with the mediating factor being the high level of difficulty in emotion regulation. Thus, emotion dysregulation has negative impacts on treatment outcomes for ED patients with CM history.

The current focus of studies is primarily on the challenges related to emotion regulation and its mediating role rather than on the use of various emotion regulation strategies. There are few studies that specifically examine emotion regulation strategies as a mediator. For example, in a recent study conducted by Dawson et al. (2022), an examination was made

into the mediating role of emotion regulation strategies, such as cognitive reappraisal and intrusive thoughts. The study findings indicate that an adaptive emotion regulation strategy, cognitive reappraisal adversely mediates the relationship between childhood emotional neglect and disordered eating behaviors. Furthermore, it was revealed that the maladaptive strategy of intrusive thoughts strengthens the relationship between emotional, sexual, and physical abuse and eating disorders.

Based on the available evidence, it can be argued that difficulties in emotion regulation play a significant mediating role between CM and EDs. However, the specific emotion regulation strategies responsible for this relationship are not yet fully understood. More specifically, there is a lack of literature focusing on the mediating role of cognitive emotion regulation strategies (CERS) on the association between CMs and EDs. While cognitive behavioral treatments are commonly used for ED symptomatology (Linardon & Brennan, 2017), addressing this gap in the literature by specifically considering both adaptive and maladaptive CERS may lead to more effective treatment outcomes. Incorporating a focus on CERS into treatment protocols could help individuals develop healthier ways of processing emotions, potentially reducing the reliance on maladaptive eating behaviors to regulate their emotions.

To address the gap in the literature, this study primarily aimed to explore the mediating role of CERS in the relationship between CM and EDs among the general population in Turkiye. More explicitly, this study examined the mediating role of adaptive and maladaptive CERS in the relationship between different types of CM and the total score of EDs.

Questions of the research are as follows:

I. Do maladaptive cognitive emotion regulation strategies significantly mediate the relationship between the types of childhood maltreatment (physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, and parental overprotection-overcontrol) and eating disorders?

II. Do adaptive cognitive emotion regulation strategies significantly mediate the relationship between the types of childhood maltreatment (physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, and parental overprotection-overcontrol) and eating disorders?

2.7. Conclusion

This chapter reviewed relevant literature on eating disorders, including diagnostic criteria, prevalence, age of onset, treatment techniques, and adverse impacts on individuals' physical and psychological well-being. Emphasis was placed on understanding the complex and multifaceted nature and possible underlying factors of eating disorders, which are significant for developing effective intervention and treatment strategies. For this purpose, the transdiagnostic developmental model were employed as the research framework. McLaughlin's transdiagnostic developmental model is based on the premise that childhood trauma exposure, such as childhood maltreatment, can have transdiagnostic features, potentially contributing to the development of various psychological disorders. These experiences can lead to psychiatric disorders such as eating disorders through distortions in emotional processes, such as application of maladaptive emotion regulation strategies.

This literature review that focuses on the relationship between childhood maltreatments and eating disorders showed that there is an extensive body of research that demonstrates they are significantly associated. However, limited research exists that examines all types of childhood maltreatment in one study; instead, most research only focuses on one aspect of maltreatment, such as neglect or abuse. Additionally, there is a scarce of literature examining overprotective and overcontrolling parenting styles, a form of childhood maltreatment, and their potential impact on the development of eating disorders. To address the gap in the literature, this research aims to examine the associations between all types of childhood maltreatment, including physical, emotional, and sexual abuse, as well as physical and emotional neglect, and an overprotective and overcontrolling parenting style, with eating disorders.

Moreover, while the connection between eating disorders and childhood maltreatment has often been studied in the context of emotion-related processes, most research has focused only on the difficulties in emotion regulation. However, a limited number of studies have looked at the impact of different emotion regulation strategies. These studies suggest that the types of emotion regulation strategies used play an important role in the development of eating disorders in individuals who have experienced childhood maltreatment. This research aims to address this gap by examining the influence of both adaptive and maladaptive cognitive emotion regulation strategies on the relationship between eating disorders and childhood maltreatment.

The primary focus of this literature review is to elucidate the rationale behind studying the relationship between eating disorders, childhood maltreatment, and cognitive emotion regulation strategies through the lens of a developmental model. Furthermore, this review facilitated the identification of gaps in the literature, thereby allowing for the presentation of the research aims.

CHAPTER III

METHODOLOGY

3.1. Research Aim and Hypotheses

The main aim of this research was to explore the mediating role of cognitive emotion regulation strategies (CERS) in the relationship between childhood maltreatment (CM) and the total score of eating disorders (EDs) among the general population in Turkiye. Specifically, this study investigated the mediating role of adaptive and maladaptive CERS in the relationship between various types of CM and the total score of EDs.

The hypotheses of the study are listed as the following:

I. Maladaptive cognitive emotion regulation strategies significantly mediate the relationship between childhood maltreatment and eating disorders.
II. Adaptive cognitive emotion regulation strategies significantly mediate the relationship between childhood maltreatment and eating disorders.

Sub-hypotheses:

I. **Maladaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood physical abuse** and **eating disorders**.
II. **Maladaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood emotional abuse** and **eating disorders**.
III. **Maladaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood sexual abuse** and **eating disorders**.
IV. **Maladaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood physical neglect** and **eating disorders**.

V. **Maladaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood emotional neglect** and **eating disorders**.

VI. **Maladaptive** cognitive emotion regulation strategies significantly mediate the relationship between **parental overprotection-overcontrol** and **eating disorders**.

VII. **Adaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood physical abuse** and **eating disorders**.

VIII. **Adaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood emotional abuse** and **eating disorders**.

IX. **Adaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood sexual abuse** and **eating disorders**.

X. **Adaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood physical neglect** and **eating disorders**.

XI. **Adaptive** cognitive emotion regulation strategies significantly mediate the relationship between **childhood emotional neglect** and **eating disorders**.

XII. **Adaptive** cognitive emotion regulation strategies significantly mediate the relationship between **parental overprotection-overcontrol** and **eating disorders**.

3.2. Research Design

As Creswell (2015) highlights, quantitative research design effectively identifies trends, explores relationships between variables, and engages large populations. Therefore, the quantitative research design was found to be more effective in achieving this study's objectives since it seeks to examine the variable relationships and the size of a large target population. A cross-sectional survey design was implemented, as it efficiently gathers data quickly and is ideal for assessing current attitudes and behaviors in larger groups (Creswell, 2015). Even though this method has limitations in establishing causality and analyzing behavior over time, it remains a valuable resource for describing the prevalence of attitudes and behaviors and analyzing the relevance of different paradigms (Kesmodel, 2018). Therefore, scales were selected as research instruments, with participants instructed to complete the forms at a designated time.

3.3. Participants

The research was conducted among the general population of individuals aged eighteen and older in Turkiye. Non-probability sampling methods were employed for recruitment. Non-probability sampling is characterized by the fact that not every individual in the research population has an equal opportunity to be included in the study (Elfil & Negida, 2016). Non-probability sampling encompasses a range of data collection methods. Among them, convenience sampling and snowball sampling methods were employed in the present study. In the convenience sampling approach, participants were selected by the researcher based on their accessibility and willingness to participate in the study (Creswell, 2015). Participants were reached via social media platforms, allowing those who were willing and available at the time to engage with the research instruments. Snowball sampling, on the other hand, involves requesting participants to share the study with their acquaintances (Elfil & Negida, 2016). In this study, participants were encouraged to forward the survey link to others within their networks.

3.4. Data Collecting Procedure

The ethical approval has been obtained from the Human Research Ethics Committee of Ibn Haldun University. Data collection was initiated through the distribution of measures via SurveyMonkey on social media for the study. Participants provided informed consent before accessing the survey, which outlined the study's purpose, confidentiality and anonymity of responses, and their voluntary participation. They were informed of their right to withdraw at any time without explanation or consequences, and contact details for the researchers and ethics committee were provided for any questions.

The survey was organized across several pages, with each scale displayed individually. Consequently, question numbers were unique to each page and restarted for every section. It included a demographic form with 11 questions and three scales: the Childhood Trauma Questionnaire (CTQ) featuring 33 questions, the Cognitive Emotion Regulation Questionnaire (CERQ) containing 36 questions, and the Eating Disorder Examination

Scale—Short Form (EDE-Q-13) with 13 questions. Overall, the survey encompassed 93 questions and took approximately 15 to 20 minutes to complete.

3.4.1. Demographic Form

The demographic form was designed to collect background information about the participants. They were asked about their gender identity (female vs. male), year of birth, educational background (primary education, lower secondary education, upper secondary education, associate degree, bachelor's degree, master's degree, doctoral degree), relationship status (single, married, in a romantic relationship, divorced, widowed), physical characteristics such as weight (in kg) and height (in cm) for calculating Body Mass Index (BMI), employment status (employed, unemployed), income level (low, low-middle, middle, middle-high, high), and any history of mental health diagnoses, with an open-ended question for those with a diagnosis. They were also asked about eating disorder diagnoses with an open-ended question for additional details. Furthermore, participants were inquired about any past or ongoing treatments they may have received for an eating disorder. The purpose of collecting this information was to gain a better understanding of the study outcomes concerning their individual differences.

3.4.2. Childhood Trauma Questionnaire – Expanded (CTQ-33)

The Childhood Trauma Questionnaire (Bernstein et al., 1994) was initially developed as a 70-item scale to assess retrospective childhood maltreatment in the forms of physical neglect, emotional neglect, physical abuse, and emotional abuse. The participants are expected to rate themselves on a 5-point Likert scale from 1 (never true) to 5 (very often true). Due to the length of the scale being time-consuming, Bernstein et al. (2003) conducted an exploratory and confirmatory factor analysis of the CTQ to refine it to a shorter version. The new form consisted of 28 items with four of the same subscales and three validity items.

The Turkish adaptation of the scale was shown to be as valid and reliable as the original scale based on the reliability and validity tests conducted by Şar et al. (2012). CTQ-28 was widely used and tested repeatedly in many studies in Turkiye. However, the studies demonstrated a need for a better cultural adaptation of the scale in terms of wording and an additional subscale that assesses the dimension of common Turkish parenting habits of overprotection and overcontrol (Şar et al., 2021). Consequently, Şar et al. modified the CTQ-28 to make it more suitable for the Turkish culture and context. Hence, the scale was extended into CTQ-33 (Şar et al., 2021) with the addition of 5 items for parental overprotection and overcontrol (OP-OC). The reliability scores for the CTQ-33 were determined to be a Cronbach alpha score of 0.87 and a Gutmann split-half coefficient of 0.69. The construct validity results indicated strong correlations between the total scores of the CTQ-33 and both the original scale ($r = 0.94$, $p < 0.001$) and the revised CTQ-28 ($r = 0.98$, $p < 0.001$). Additionally, the revised subsections showed strong correlations: CEA ($r = 0.88$, $p < 0.001$), CPN ($r = 0.95$, $p < 0.001$), and CEN ($r = 0.93$, $p < 0.001$). Furthermore, it was found that the total scores of CTQ-33 have a moderate yet significant association with dissociation ($r = 0.29$, $p < 0.001$) and depression ($r = 0.34$, $p < 0.001$).

Consequently, the CTQ-33, the modified and expanded version of CTQ-28, is considered both valid and reliable. In this research, the CTQ-33 was utilized, with the Cronbach alpha scores of its subscales ranging from 0.75 to 0.88 in the current study. Table 3.1 presents the detailed Cronbach alpha scores for this study as well as those reported by Şar et al. (2021). The assessment of CM was based on the total score obtained by summing all items. Each subscale's score, which assesses different types of maltreatment, was calculated by summing the corresponding items.

Table 3.1. Reliability Coefficients (α) for CTQ-33 Subscales in the Current Study and Turkish Adaptation

CTQ-33 Subscales	α in the current study	α in Turkish adaptation (Şar et al., 2021)
CPA	0.87	0.81
CEA	0.86	0.88
CSA	0.88	0.90
CPN	0.80	0.77
CEN	0.75	0.89
Parental OP-OC	0.84	0.84

3.4.3. Eating Disorder Examination Scale – Short Form (EDE-Q-13)

The Eating Disorder Examination Questionnaire (EDE-Q) was developed by Fairburn and Beglin (1994) to eliminate the disadvantages of investigator-based interviews. These interviews were costly, time-consuming, and could be considered personally intrusive, as it might be challenging for patients to admit to vomiting or binge eating behaviors in person. Therefore, it was aimed that using a questionnaire to assess disorder symptomatology could have an eliminating impact on these disadvantages. EDE-Q contains 28 questions, is based on a 7-point rating scale, and the frequency of behavior is measured in terms of the number of days. The scale has two main limitations. Firstly, the length of the questionnaire takes up a lot of time, making it uneconomical. Secondly, the scoring process does not include binging and purging items, as they are asked as open-ended questions (Esin & Ayyıldız, 2022). Scholars proposed various short versions of EDE-Q to overcome the first limitation. Among them, EDE-Q-7 was evaluated in many studies and found reliable and valid (Grilo et al., 2013; Jenkins & Davey, 2020; Machado et al., 2020; Tobin et al., 2019). However, EDE-Q-7, similar to the latter limitation of EDE-Q, does not measure bingeing and purging behaviors and is limited to three dimensions: dietary restraints, shape weight overvaluation, and body dissatisfaction.

However, bingeing and purging are required to evaluate for assessing eating disorder symptomatology (Machado et al., 2020).

Therefore, EDE-Q-13 (Lev-Ari et al., 2021a) was developed. It contains the subscales that EDE-Q and other short forms include, besides bingeing and purging behaviors. Additionally, because it is almost half the length of the original form, it is much less time-consuming. Other than the differences, EDE-Q-13 is also based on a 7-point Likert-type scale and measures the frequency in terms of the number of occurrences in the past 28 days. Lev-Ari et al. (2021) tested the validity and reliability of the scale, and they were found as satisfactory. The concurrent validity of EDE-Q-13 was assessed by correlating total scores and subscales with EDE-Q. Results showed there is a strong correlation between the total score of EDE-Q and EDE-Q-13 ($r = 0.92$, $p < 0.001$)

The present study employed the Turkish version of the EDE-Q-13 questionnaire, which was translated and adapted by Esin and Ayyıldız (2022). The total scale demonstrated a high level of internal consistency, with a Cronbach's alpha value of .89. Additionally, each subscale showed good reliability, with internal consistency ranging from .75 to .94. To assess criterion validity, the researchers found a significant positive correlation between EDE-Q-13 and Eating Attitudes Test-26, as well as significant negative correlations with the scale of Satisfaction with Life. As a result, the Turkish EDE-Q-13 proved to be both reliable and valid. In this study, the Cronbach alpha values varied between 0.78 and 0.93. Table 3.2 presents a detailed comparison of the reliability coefficients for the subscales in this study, the Turkish adaptation (Esin & Ayyıldız, 2022), and the original scale (Lev-Ari et al., 2021). This study aims to evaluate the total score of ED symptoms among the general population. For this purpose, all items of the scale were summed and analyzed.

Table 3.2. Reliability Coefficients (α) for EDE-Q-13 Subscales in the Current Study, Turkish Adaptation, and the Original Scale

EDE-Q-13 Subscales	α in the current study	α in Turkish adaptation (Esin & Ayyıldız, 2022)	α in the original scale (Lev-Ari et al., 2021)
Eating restraint	0.92	0.92	0.92
Shape and weight over-evaluation	0.93	0.94	0.99
Body dissatisfaction	0.90	0.93	0.89
Bingeing	0.87	0.84	0.89
Purging	0.78	0.75	0.63

3.4.4. Cognitive Emotion Regulation Questionnaire (CERQ)

The measure was developed by Garnefski et al. (2001) to fill the gap in the literature for assessing the cognitive aspect of emotion regulation in response to adverse life events. CERQ includes nine cognitive emotion regulation strategies, namely, *self-blame, acceptance, rumination, putting into perspective, positive focus, refocusing on planning, positive reappraisal, catastrophizing, and blaming others.* Four items assess each cognitive emotion regulation strategy, and the scale consists of 36 items in total. Participants evaluate themselves using a 5-point Likert scale that ranges from "almost never" (1) to "almost always" (5). The total score obtained from each scale illustrates which cognitive emotion regulation strategy is mainly used by the participant. Thus, the minimum score of a subscale is 4, and the maximum is 20.

The current study utilized the Turkish form of CERQ that was adapted by Tuna and Bozo (2012) and consists of nine subscales and employs a 5-point Likert scale, the same as the original form. The internal reliability score for the subscales ranged from $\alpha = 0.72$ to $\alpha = 0.83$. Additionally, according to the test-retest reliability, correlation coefficients of subscales were found to vary between $\alpha = 0.50$ and $\alpha = 0.70$. In terms of validity, criterion

and construct tests were conducted, and the scale was found to be valid. In this study, the Cronbach alpha scores for the CERQ subscales varied between $\alpha = 0.74$ and $\alpha = 0.86$. Table 3.3 presents the reliability coefficients from the current research, as well as comparisons with the Turkish adaptation (Tuna & Bozo, 2012) and the original scale (Garnefski & Kraaij, 2007). For the analysis, the total score of the subscales was calculated by summing all items of the particular subscale. Additionally, the current study classified CERS into two categories, adaptive CERS and maladaptive CERS, based on subscale correlations and the classification of the existing literature (Garnefski et al., 2001; Tuna & Bozo, 2012). The literature review and result chapters provide detailed information based on the classification.

Table 3.3. Reliability Coefficients (α) for CERQ Subscales in the Current Study, Turkish Adaptation, and the Original Scale

CERQ Subscales	α in the current study	α in Turkish adaptation (Tuna & Bozo, 2012)	α in the original scale (Garnefski & Kraaij, 2007)
Self-blame	0.80	0.72	0.75
Acceptance	0.74	0.74	0.76
Rumination	0.84	0.82	0.83
Positive refocusing	0.81	0.81	0.87
Refocus on planning	0.78	0.81	0.86
Positive reappraisal	0.84	0.79	0.84
Putting into perspective	0.75	0.75	0.83
Catastrophizing	0.85	0.83	0.79
Blaming others	0.86	0.82	0.81

3.5. Data Analysis

Upon completion of the data cleaning procedure in SPSS version 29, the normality of the data was assessed. The normal distribution of the data was evaluated using the

Kolmogorov-Smirnov test, a widely recognized method for assessing normality when the sample size exceeds 300 (Mishra et al., 2019). The results indicated that the data did not follow a normal distribution, as evidenced by a p-value lower than the predetermined significance level of 0.05. Given that parametric tests necessitate a normal data distribution, nonparametric tests were employed in line with the requirements of this research.

The participants' sociodemographic characteristics were summarized using descriptive statistics. Frequencies and percentages were computed for categorical variables such as gender, education level, income level, relationship status, BMI category (calculated from participants' weight and height), history of psychopathological diagnoses other than eating disorders, and history of eating disorder diagnosis. For the continuous variables—including total scores and all subscales of CTQ-33, EDE-Q-13, and CERQ—the mean, standard deviation, and range were calculated.

A correlation analysis was conducted to categorize the subscales of CERQ into adaptive and maladaptive CERS. For this purpose, the Spearman rank correlation coefficient (r_s), a non-parametric measure, was utilized. Spearman's correlation analysis is advantageous for assessing non-normally distributed data and is more convenient as it does not require a specific data ranking (Xiao et al., 2016). Correlation analysis was also conducted to assess the direction and the strength of the relationship between the key continuous variables of the research. The correlation between all subscales of CTQ, two categories of CERS, and the total score of EDE-Q-13 were assessed.

In order to demonstrate the impact of adaptive and maladaptive CERS on the link between different types of CM and the overall score of EDs, a series of mediation analyses was conducted using the PROCESS Macro Model 4 (A. F. Hayes, 2022) in SPSS-29. The mediation analyses explored the mediating impact of adaptive and maladaptive CERS on the relationship between the overall ED score and six subtypes, as well as the total CM score. A total of 14 mediation analyses were performed.

CHAPTER IV

RESULTS

This chapter presents the analyses conducted to explore the mediating role of adaptive and maladaptive cognitive emotion regulation strategies (CERS) in the relationship between childhood maltreatment (CM) and eating disorders (EDs). It begins with a preliminary analysis detailing the missing data procedures and dropout rates. Subsequently, descriptive analyses were reported for demographic variables, including age, gender, education level, income level, marital status, and BMI score, along with descriptive statistics for the scores of the main variables of the study. Additionally, information regarding the prevalence rates for types of CM was provided. A correlation analysis was conducted to categorize CERS as adaptive or maladaptive, followed by a second correlation analysis to examine the associations between the main variables. Finally, fourteen models of mediation analysis were reported to test the hypotheses.

4.1. Preliminary Analysis

As stated in Chapter III, the data collection procedure was conducted through an online survey platform, SurveyMonkey. The feature provided by SurveyMonkey was activated, preventing participants from proceeding to the next page without answering all questions. Therefore, among the completed surveys, there was no missing data, which did not require researchers to apply the missing data procedure. However, a substantial number of participants dropped out. More specifically, out of 575 individuals who agreed to give consent for the survey, only 352 finished it, while 223 surveys were left incomplete. There can be various explanations for the 38% of dropouts of the survey. For example, items addressing sensitive memories, such as childhood abuse and neglect, may cause triggers for individuals and restrict them from completing the form. Fortier et al. (2020) found that questions related to sensitive issues like CM were not a major source of distress; they

noted that CM-related items might discourage individuals from completing the questionnaire due to emotional distress or stigma concerns. Conversely, some individuals may feel the questionnaire is irrelevant to their circumstances. Research indicates that lack of engagement is a significant contributor to survey non-completion (Mann, 2024). Moreover, the current study survey's length—94 items—can be overwhelming for individuals because the length of the survey also contributes to higher dropout rates in online surveys (Hoerger, 2010). Other factors, such as time constraints, disinterest, or personal issues, can also lead to non-completion (Dey & Mohler-Kuo, 2013).

4.2. Descriptive Statistics

The analysis was conducted on a sample of 352 individuals that filled out the survey, aged 18 years and older. Among them, 310 participants identified as female, and 42 identified as male. The mean score for age was 29.55 years (*Mdn* = 28, *SD* = 8.63, range = 18 - 79). The study included a group of participants with a relatively high level of education. The majority of participants had a Bachelor's degree (*n* = 179; 50.9%), followed by those with a Master's degree (*n* = 99; 28.1%). In terms of socioeconomic status, the majority of participants identified their income level as the middle (*n* = 177; 50.3%), and 38.6% fell within the low-middle income range (*n* = 136). Regarding relationship status, there were 160 single participants, and their number was almost equal to the combined number of those who were either married or in a romantic relationship (118 and 68, respectively).

The participants' height and weight information were collected to compute their Body Mass Index (BMI) score. BMI is derived by dividing an individual's weight in kilograms by the square of their height in meters. The categorization based on BMI scores is as follows: individuals are categorized as underweight if their BMI is below 18.5, normal if it falls between 18.5 and 24.99, overweight if it ranges from 25 to 29.99, obese if it is between 30 and 34.9, and extremely obese if it exceeds 35 (CDC, 2024). Based on the BMI categorization, the majority of the participants were normal in weight (*n* = 197; 56.1%), 6.8% were underweight, 24.1% were overweight, 9.9% were obese, and finally, 3.1 were extremely obese. Table 4.1 displays more detailed demographic information.

The participants were also asked about any psychopathological diagnoses. It was found that 22.4% of the participants received a diagnosis other than eating disorders, while only 5.4% were diagnosed with eating disorders. Since the research population was not clinical, the low number of individuals diagnosed with eating disorders was expected

Table 4.1. Sociodemographic Characteristics of Participants

Variable	***N***	***n***	**%**
Gender	352		
Woman		310	88.1
Man		42	11.9
Education Level	352		
Primary School		3	0.9
Middle School		1	0.3
High School		22	6.3
Associate Degree		24	6.8
Bachelor's Degree		179	50.9
Master's Degree		99	28.1
Doctoral Degree		24	6.8
Income Level	352		
Low		35	9.9
Low-Middle		136	38.6
Middle		177	50.3
Middle-High		0	0
High		4	1.1
Relationship Status	352		
Single		160	45.5
Married		118	33.5

Table 4.1. (cont.)

Variable	***N***	***n***	**%**
In a romantic relationship		68	19.3
Divorced/Widowed		6	1.7
BMI	352		
Underweight		24	6.8
Normal		197	56.1
Overweight		85	24.1
Obese		35	9.9
Extremely Obese		11	3.1
Psychopathologic diagnosis	352		
Yes		79	22.4
No		273	77.6
Eating Disorder Diagnosis	352		
Yes		19	5.4
No		333	94.6

The descriptive statistics of the study variables are given in Table 4.2. Among the subtests of CTQ-33, the highest mean values were observed for emotional neglect (*M* = 12.28, *SD* = 4.59, range = 5 - 25) and parental OP-OC (*M* = 11.41, *SD* = 4.48, range = 5 - 25). Furthermore, the study identified the highest mean value for an adaptive CERS as "refocus on planning," scoring 14.50 (*M* = 14.50, *SD* = 2.93, range = 4 – 20) while the highest mean value for a maladaptive strategy was for rumination, scoring 14.99 (*M* = 14.99, *SD* = 3.36, range = 4 - 20). Based on the findings, the mean value of the total score on the EDE-Q-13 was 23.26 out of 78 (*M* = 23.26, *SD* = 17.24, range = 0–78), indicating an average score with a notable degree of variability. The highest mean value was found in body dissatisfaction (*M* = 6.40, *SD* = 4.70, range = 0–12), followed by eating restraint (*M* = 6.44, *SD* = 5.84, range = 0–18) and overvaluation of body shape and weight (*M* = 5.63, *SD* = 4.56, range = 0–12). The lowest mean score was for purging (*M* = 0.78, *SD* = 2.26, range = 0–18).

Table 4.2. Descriptive Statistics for Scales and Subscales

Variable	*M*	*SD*	Range
CTQ-33 Total Score	53.94	16.56	30-153
Physical Abuse	6.29	3.01	5-25
Emotional Abuse	9.26	4.28	5-25
Sexual Abuse	6.55	2.90	5-25
Physical Neglect	7.89	2.96	5-25
Emotional Neglect	12.28	4.59	5-25
Parental OP-OC	11.41	4.48	5-25
Denial	0.25	0.61	0-3
CERQ			
Acceptance	12.84	3.17	4-20
Positive refocusing	11.44	3.26	4-20
Refocus on planning	14.50	2.93	4-20
Positive reappraisal	13.32	3.44	4-20
Putting into perspective	12.48	2.98	4-20
Self-blame	12.20	3.49	4-20
Rumination	14.99	3.36	4-20
Catastrophizing	10.40	3.84	4-20
Blaming others	10.56	3.28	4-20
EDE-Q-13 Total Score	23.26	17.24	0-78
Eating Restraint	6.44	5.84	0-18
Overvaluation of Body Shape and Weight	5.63	4.56	0-12
Body Dissatisfaction	6.40	4.70	0-12
Binging	4.02	4.67	0-18
Purging	.78	2.26	0-18

Note. CTQ-33 = Childhood Trauma Questionnaire-33; CERS = Cognitive Emotion Regulation Questionnaire; EDE-Q-13 = Eating Disorder Examination Questionnaire-13.

N = 352

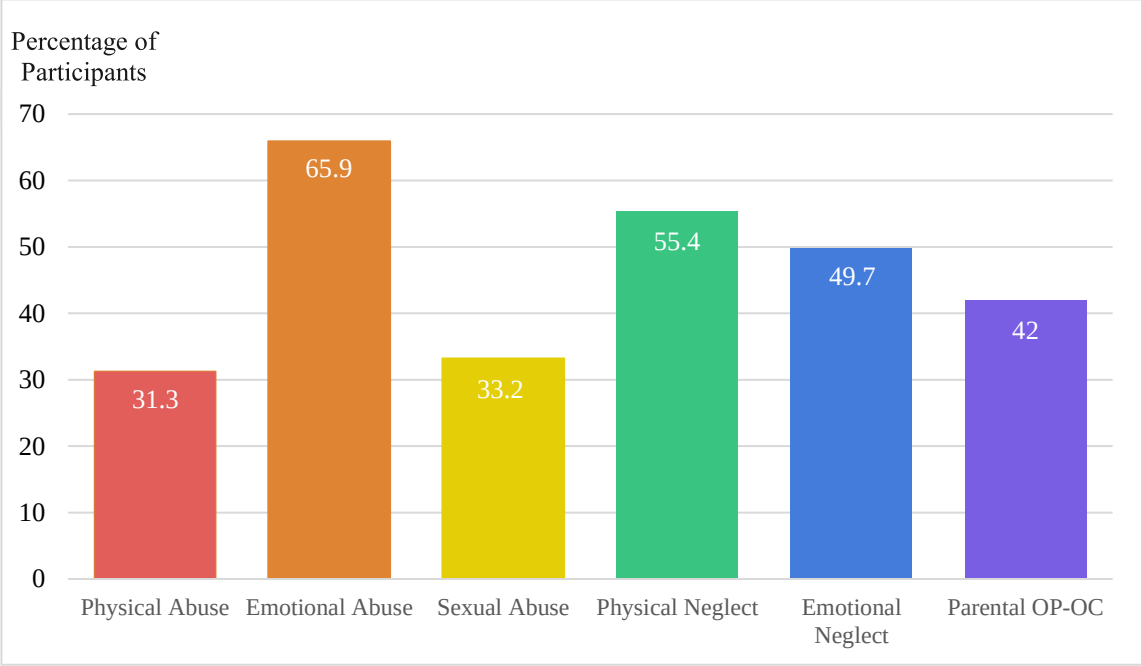
4.2.1. Prevalence Rates of Childhood Maltreatment Types

To determine the prevalence rates of CM, the cut-off scores for each type were utilized as outlined by Şar et al. (2012), with the exception of parental OP-OC, as this aspect was incorporated in later versions of the scale. The cut-off score for sexual and physical abuse was set at 5. For emotional abuse and physical neglect, it was established at 7, while emotional neglect received a cut-off of 12. Due to the absence of a specified cut-off for parental OP-OC, the mean value of 11.41 was adopted as its cut-off. Similarly, since no cut-off score was defined for the total score of the expanded CTQ form, the mean value of 53.94 was employed. The findings are presented in Table 4.

Table 4.3. Prevalence Rates of Childhood Maltreatment

Variable	***N***	***n***	**%**
	352		
Total Score of CM		141	40.1
	352		
Physical Abuse		110	31.3
	352		
Emotional Abuse		232	65.9
	352		
Sexual Abuse		117	33.2
	352		
Physical Neglect		195	55.4
	352		
Emotional Neglect		175	49.7
	352		
Overprotective - Overcontrol		148	42.0

The findings indicate that 40.1% of the participants reported a significant degree of exposure to childhood maltreatment. Among the types of abuse, emotional abuse has the highest ratio at 65.9%, followed by sexual abuse at 33.2% and physical abuse at 31.3%. Types of neglect were reported by at least half of the participants. Specifically, physical neglect is at 55.4%, and emotional neglect is at 49.7%. Finally, parental OP-OC was reported by 42% of the participants. The results are illustrated in Figure 4.1.



Graphic 4.1. The Prevalence of the Types of Childhood Maltreatment in the General Population of Türkiye

4.3. Correlation Analyses

4.3.1. Categorizing Cognitive Emotion Regulation Strategies

The Cognitive Emotion Regulation Questionnaire (Garnefski et al., 2001) consists of nine cognitive strategies to regulate emotions. Based on the relevant literature, these strategies can be grouped into two categories: adaptive and maladaptive based on their associations with emotional problems, depression, and anxiety (Garnefski & Kraaij, 2006; Kraaij et al., 2003; Tuna & Bozo, 2012). Eight of the nine strategies show consistent relationships.

Specifically, *self-blame, rumination, catastrophizing*, and *blaming others* are maladaptive as they are linked to each other and various psychopathologies. In contrast, *positive refocusing, refocusing on planning, positive reappraisal*, and *putting into perspective* are adaptive due to their negative associations with psychopathologies. However, there are inconsistencies regarding the *acceptance* subscale (Tuna & Bozo, 2012). *Acceptance* is theoretically considered (Carver et al., 1989) and empirically found (Garnefski et al., 2001; Overall, 2019; Sugiura et al., 2023) to be an adaptive strategy; however, it was also found to be related to various psychological complications (Martin & Dahlen, 2005; Tuna & Bozo, 2012a). Therefore, categorizing the *acceptance* subscale of CERQ among the adaptive strategies can be misleading. There is a need for more research to understand the responsible factors for this subscale showing significant relations with psychological disorders (Tuna & Bozo, 2012). Consequently, to achieve more accurate results and eliminate the inconsistency as much as possible, this study categorized adaptive and maladaptive strategies based on the correlations of the subscale scores between each other in the current data. Furthermore, the relationship between subscale scores and the total score of EDs was examined as the literature indicates a positive link between maladaptive CERS and psychological disorders.

In Chapter III, it was explained that the Kolmogorov-Smirnov test indicated that the data in this study does not follow a normal distribution. Therefore, Spearman's correlation, a non-parametric correlation test, was used for correlation analysis and to assess the relationships between the subscales of the CERQ. The results of the Spearman correlation analysis are presented in Table 4.4.

As mentioned above, four strategies—positive refocusing, refocus on planning, positive reappraisal, and putting into perspective—are classified as adaptive due to their consistent negative associations with psychological complications. In the current study, these strategies demonstrated significant positive associations with each other. More specifically, positive refocusing was significantly correlated with refocus on planning ($r_s = 0.34$, $p < 0.001$), positive reappraisal ($r_s = 0.53$, $p < 0.001$), and putting into perspective ($r_s = 0.25$, $p < 0.001$). Similarly, refocus on planning showed significant positive

correlations with positive reappraisal (r_s = 0.64, p < 0.001) and putting into perspective (r_s = 0.28, p < 0.001). Finally, positive reappraisal was significantly associated with putting into perspective (r_s = 0.46, p < 0.001). These associations highlight the interconnectedness of adaptive strategies based on the present data.

The remaining strategies—excluding acceptance—are well-established as maladaptive and were also found to be significantly and positively associated with each other. For example, self-blame was significantly correlated with rumination (r_s = 0.48, p < 0.001) and catastrophizing (r_s = 0.45, p < 0.001). Rumination showed significant positive correlations with Catastrophizing (r_s = 0.32, p < 0.001) and Blaming Others (r_s = 0.17, p < 0.05), while Catastrophizing and Blaming Others were also significantly correlated (r_s = 0.43, p < 0.001). Additionally, Catastrophizing demonstrated significant negative correlations with Positive Refocusing (r_s = -0.17, p < 0.001) and Positive Reappraisal (r_s = -0.28, p < 0.001), while Self-Blame was negatively correlated with Positive Refocusing (r_s = -0.25, p < 0.001).

Although rumination positively correlates with three adaptive strategies—refocus on planning (rs = 0.38, p < 0.001), positive reappraisal (rs = 0.17, p < 0.001), and putting into perspective (rs = 0.11, p < 0.05)—its coefficient values were higher for maladaptive strategies. Furthermore, rumination is well established as having positive associations with various psychopathologies, leading to its classification as a maladaptive strategy. This finding is crucial for understanding Garnefski et al. (2001), who label these strategies as less adaptive strategies rather than maladaptive ones. Although typically termed maladaptive, they can be adaptive in specific situations. Individuals may use these strategies alongside cognitive problem-solving techniques like refocusing on planning, positive reappraisal, and putting into perspective as a response to different stressors or circumstances (Compas et al., 2017; Joormann & Stanton, 2016).

By conducting this correlation analysis, the main aim was to clarify the role of acceptance, which is usually considered an adaptive strategy but shows contradicting results. The findings underscore the relevance of this aim, as acceptance was positively associated with

only one adaptive strategy, putting into perspective ($r_s = 0.25$, $p < 0.001$), but showed significant positive correlations with all maladaptive strategies, including self-blame ($r_s = 0.55$, $p < 0.001$), rumination ($r_s = 0.35$, $p < 0.001$), catastrophizing ($r_s = 0.39$, $p < 0.001$), and blaming others (0.25, $p < 0.001$). Furthermore, when examining correlations with the total score of EDs, the established adaptive strategies showed no significant association, while the remaining strategies, including acceptance, displayed significant positive correlations with the total score of EDs. Specifically, self-blame ($r_s = 0.21$, $p < 0.001$), acceptance ($r_s = 0.17$, $p < 0.001$), rumination ($r_s = 0.16$, $p < 0.001$), catastrophizing ($r_s = 0.17$, $p < 0.001$), and blaming others ($r_s = 0.12$, $p < 0.05$) were all positively correlated with the overall score of EDs.

Table 4.4. Spearman Correlation between Subscales of CERQ

N = 352	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1. Self Blame	-									
2. Acceptance	.55***	-								
3. Rumination	.48***	.35***	-							
4.Positive Refocusing	-.25***	-.07	-.03	-						
5.Refocus on Planning	.07	.01	.38***	.35***	-					
6.Positive Reappraisal	-.08	.02	.17***	.53***	.64***	-				
7.Putting into Perspective	.09	.25***	.11**	.25***	.28***	.46***	-			
8.Catastrophizing	.45***	.39***	.32***	-.17***	-.07	-.28***	-.09	-		
9. Blaming Others	.05	.25***	.17**	.03	.02	-.10	.06	.43***	-	
10.Total Score of EDs	.21***	.17***	.16***	.01	.01	-.06	.05	.17***	.12**	-

** $p < .05$; *** $p < .001$

In conclusion, although acceptance is generally considered an adaptive strategy, this study found it to be more closely aligned with maladaptive strategies. This finding mirrors

results from the Turkish adaptation of the CERQ, which also found acceptance as associated with psychological complications (Tuna & Bozo, 2012). Based on these findings, the categorization of strategies is presented in Table 4.5.

Table 4.5. Categorization of the Cognitive Emotion Regulation Strategies

Variable	***M***	***SD***	**Range**
CERQ – Adaptive Strategies	51.74	9.73	16-80
Positive refocusing	11.44	3.26	4-20
Refocus on planning	14.50	2.93	4-20
Positive reappraisal	13.32	3.44	4-20
Putting into perspective	12.48	2.98	4-20
CERQ – Maladaptive Strategies	60.98	12.27	20-100
Acceptance	12.84	3.17	4-20
Self-blame	12.20	3.49	4-20
Rumination	14.99	3.36	4-20
Catastrophizing	10.40	3.84	4-20
Blaming others	10.56	3.28	4-20

4.3.2. Correlation between the Main Variables

A Spearman correlation analysis was conducted to gain a prior understanding of the associations between the main variables of the current study. These results are presented in Table 4.6.

The study utilized all subscales of the childhood maltreatment questionnaire (CTQ-33), the total score of the eating disorder questionnaire (EDE-Q-13), the total score of adaptive CERS (positive refocusing, refocus on planning, positive reappraisal, putting into perspective), and the total score of maladaptive CERS (acceptance, self-blame, rumination, catastrophizing, blaming others). The results showed that the total score for EDs had a significant correlation with all types of CM. The highest correlation was found

with CPA (r_s = 0.25, p < 0.001), followed by CEA (r_s = 0.23, p < 0.001). The total score of eating disorders also correlated significantly with parental OP-OC (r_s = 0.18, p < 0.001), CEN (r_s = 0.17, p < 0.01), CPN (r_s = 0.16, p < 0.05), and CSA (r_s = 0.12, p < 0.05). Additionally, the total score of EDs showed a significant correlation with the total score of CM (r_s = 0.24, p < 0.01).

The total score of the adaptive CERS demonstrated negative significant correlations with most types of CM, and the strongest association was found with CEN (r_s = -0.25, p < 0.001). There were also significant associations with CEA (r_s = -0.16, p < 0.05), CPN (r_s = -0.13, p < 0.05), and parental OP-OC (r_s = -0.19, p < 0.001). Furthermore, adaptive strategies displayed a negative significant correlation with the total score of CM (r_s = -0.23, p < 0.05). Conversely, the total score of the maladaptive CERS showed positive significant correlations with the total score of EDs and all types of CM. Maladaptive strategies exhibited the highest correlation with CEA (r_s = 0.47, p < 0.001), followed by parental OP-OC (r_s = 0.33, p < 0.001), and CEN (r_s = 0.19, p < 0.001). Additionally, maladaptive strategies displayed significant correlations with CSA(r_s = 0.19, p < 0.001), CPA (r_s = 0.18, p < 0.001), and CPN (r_s = 0.14, p < 0.001). Finally, maladaptive strategies were significantly correlated with the total score of EDs (r_s = 0.24, p < 0.001) and the total score of CM (r_s = 0.37, p < 0.001).

Table 4.6. Spearman Correlation among the Key Variables

N = 352	***M***	***SD***	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
1. CPA	9.26	4.28	-										
2. CEA	6.29	3.01	.53**	-									
3. CSA	7.89	2.96	.45**	.35**	-								
4. CPN	12.28	4.59	.72**	.43**	.60**	-							
5. CEN	6.55	2.90	.34**	.21**	.34**	.30**	-						
6. OP-OC	11.41	4.48	.56**	.36**	.36**	.54**	.25**	-					
7. CM (Total)	53.94	16.56	.84**	.57**	.69**	.87**	.49**	.74**	-.36**	-			
8. EDs (Total)	23.26	17.24	.23**	.25**	.16**	.17**	.12*	.18**	-.09	.24**	-		
9. A. CERS	51.74	9.73	-.16**	-.06	-.13*	-.25**	-.08	-.19**	.12*	-.23**	-.02	-	
10. M. CERS	60.98	12.27	.47**	.18**	.14**	.32**	.19**	.33**	-.30**	.37**	.24**	-.08	-

Note. CPA = Childhood Physical Abuse; CEA = Childhood Emotional Abuse; CSA = Childhood Sexual Abuse; CPN= Childhood Physical Neglect; CEN = Childhood Emotional Neglect; OP-OC = Parental Overprotection – Overcontrol; CM (Total) = Total score gained from CTQ-33; EDs (Total) = Total score gained from EDE-Q-13; A. CERS = Total score of Adaptive Cognitive Emotion Regulation Strategies, including positive refocusing, refocus on planning, positive reappraisal, putting into perspective; M. CERS = Total score of maladaptive cognitive emotion regulation strategies including acceptance, self-blame, rumination, catastrophizing, blaming others.

** $p < .05$; *** $p < .001$

4.4. The Mediating Role of Cognitive Emotion Regulation Strategies

Cognitive emotion regulation strategies (CERS) have been categorized as adaptive and maladaptive strategies. This classification was based on a thorough review of existing literature and established theories, as well as an analysis of the relationships between the CERS subtests and their associations with the total score of EDs in the current research. Therefore, the adaptive CERS category encompasses positive refocusing, refocus on planning, positive reappraisal, and putting into perspective; the maladaptive CERS category includes acceptance, self-blame, rumination, catastrophizing, and blaming others.

In accordance with this classification, the mediating role of adaptive and maladaptive CERS in the relationships between all types of CM and the total score of EDs was assessed utilizing the PROCESS macro (Model 4) developed by Hayes (2022). A total of 14 mediation analyses were executed for this purpose. Appendix A presents the results of all mediation analyses. Specifically, Table A.1 shows the outcomes for the maladaptive CERS mediator, while Table A.2 displays the results for the adaptive CERS mediator. In the following sections, each mediation analysis is reported separately to evaluate the hypotheses and sub-hypotheses. To provide a coherent and systematic representation, each sub-hypothesis is articulated subsequent to the main hypothesis with which it is associated. Consequently, the principal hypothesis and its related sub-hypotheses, inclusive of the same mediator, are collectively presented in a sequential manner.

4.4.1. Testing the Hypothesis 1

The first hypothesis stated that *maladaptive cognitive emotion regulation strategies significantly mediate the relationship between childhood maltreatment and eating disorders.*

Thus, the first model tested the mediating role of maladaptive CERS in the relationship between the total score of CM and the total score of EDs. The results revealed that the

total score of CM significantly predicted the total score of maladaptive CERS (path a; *B* = 0.26, *SE* = 0.04, $p < 0.001$, 95% *CI* [0.19, 0.34]), indicating that higher levels of CM are linked to increased use of maladaptive CERS. Additionally, the total score of maladaptive CERS significantly predicted the total score of EDs (path b; *B* = 0.22, *SE* = 0.08, $p < 0.05$, 95% *CI* [0.07, 0.38]). The total score of CM showed a significant direct effect on the total score of EDs (path c'; *B* = 0.16, *SE* = 0.06, $p < 0.05$, 95% *CI* [0.05, 0.27]).

Mediation analysis revealed that maladaptive CERS significantly and partially mediate the relationship between CM and EDs (path a1b1; *B* = 0.06 *SE* = 0.02, 95% *CI* [0.01, 0.10]). This indicates that CM leads to an increased use of maladaptive CERS, which is, in turn, linked to a greater risk of developing EDs. Consequently, hypothesis 1 is accepted. The model defining the mediating role of maladaptive CERS in the relationship between the total score of CM and the total score of EDs is demonstrated in Figure 4.1.

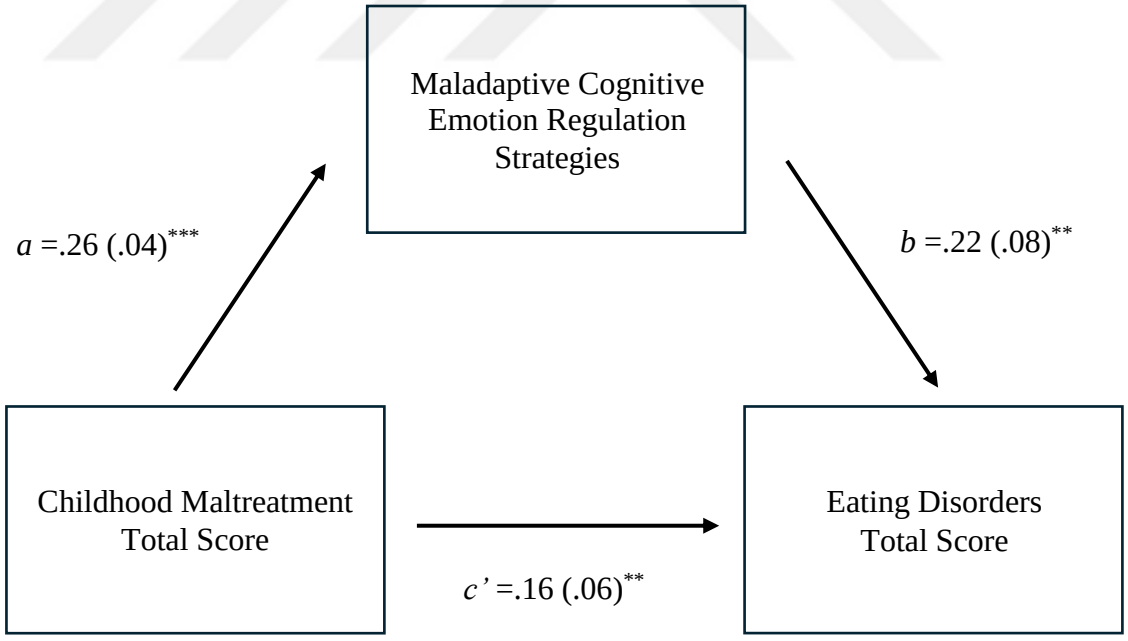


Figure 4.1. The Mediating Role of Maladaptive CERS in the Relationship between the Total Score of CM and the Total Score of EDs

4.4.1.1. Testing the Sub-Hypothesis 1

The first sub-hypothesis stated that *maladaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood physical abuse*** *and eating disorder.*

Thus, the second model examines the mediating role of maladaptive CERS in the relationship between CPA and the total score of EDs. The mediation analysis found that CPA significantly predicted maladaptive CERS (path a; $B = 0.59$, $SE = 0.22$, $p < 0.05$, 95% *CI* [0.164, 1.012]), indicating that higher levels of CPA are associated with greater use of maladaptive CERS. Additionally, maladaptive CERS significantly predicted ED symptoms (path b; $B = 0.27$, $SE = 0.07$, $p < 0.001$, 95% *CI* [0.13, 0.42]). The direct relationship between CPA and the total ED score was also statistically significant (path c'; $B = 0.79$, $SE = 0.30$, $p < 0.05$, 95% *CI* [0.199, 1.379]).

The analysis also revealed a significant indirect effect of CPA on ED symptoms through maladaptive CERS (path a1b1; $B = 0.16$, $SE = 0.07$, 95% *CI* [0.04, 0.32]), indicating partial mediation. This indicates that CPA leads to an increased use of maladaptive CERS, which is, in turn, linked to a greater risk of developing EDs. Consequently, sub-hypothesis 1 is accepted. This suggests that maladaptive CERS partially mediate the relationship between CPA and ED symptoms. The model examining the mediating role of maladaptive CERS in the relationship between CPA and the total score of EDs is demonstrated in Figure 4.2.

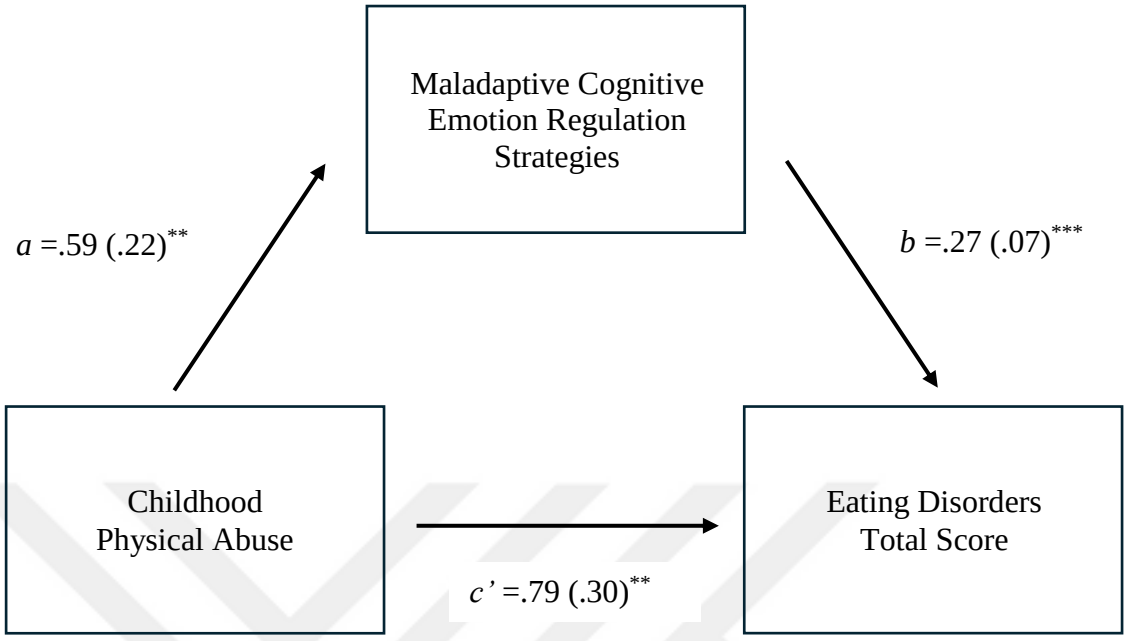


Figure 4.2. The Mediating Role of Maladaptive CERS in the Relationship between Childhood Physical Abuse and the Total Score of EDs

4.4.1.2. Testing the Sub-Hypothesis 2

The second sub-hypothesis stated that *maladaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood emotional abuse*** *and eating disorder symptomatology.*

Therefore, the third model investigates the relationship between CEA, maladaptive CERS, and EDs. The mediation analysis shows that emotional abuse significantly predicts maladaptive CERS (path a; B = 1.17, SE = 0.14, $p < 0.001$, 95% CI [0.894, 1.445]), indicating that higher levels of emotional abuse are associated with greater use of maladaptive cognitive emotion regulation strategies. Besides, maladaptive CERS significantly predicts ED symptoms (path b; B = 0.23, SE = 0.08, $p < 0.05$, 95% CI [0.069, 0.384]). The direct relationship between emotional abuse and the total ED score was also statistically significant (path c'; B = 0.50, SE = 0.23, $p < 0.05$, 95% CI [0.049, 0.951]).

The analysis further reveals a significant indirect effect of CEA on ED symptoms through maladaptive CERS (path a1b1; *B* = 0.27, *SE* = 0.11, 95% *CI* [0.05, 0.47]), suggesting partial mediation. This indicates that CEA leads to an increased use of maladaptive CERS, which is, in turn, linked to a greater risk of developing EDs. Consequently, sub-hypothesis 2 is accepted. The model showing the mediating role of maladaptive CERS in the relationship between CPA and the total score of EDs is demonstrated in Figure 4.3.

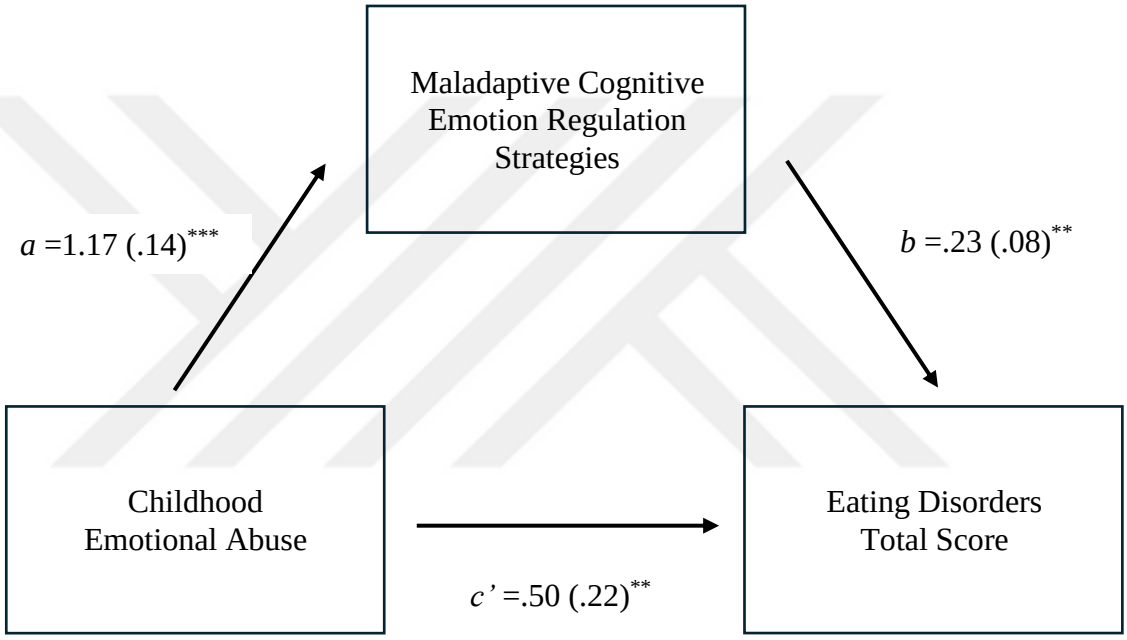


Figure 4.3. The Mediating Role of Maladaptive CERS in the Relationship between Childhood Physical Abuse and the Total Score of EDs

4.4.1.3. Testing the Sub-Hypothesis 3

The third sub-hypothesis stated that *maladaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood sexual abuse*** *and eating disorder.*

Hence, the fourth model explores the relationship between CSA and maladaptive CERS, and eating disorders (EDs). The mediation analysis found that CSA was a significant predictor of maladaptive CERS (path a; *B* = 0.68, *SE* = 0.22, $p < 0.05$, 95% *CI* [0.235,

1.115]), indicating that higher levels of CSA are associated with greater use of maladaptive CERS. Additionally, maladaptive CERS significantly predicted ED symptoms (path b; *B* = 0.28, *SE* = 0.07, *p* < 0.001, 95% *CI* [0.138, 0.431]).

The direct relationship between CSA and the total ED score was not statistically significant (path c'; *B* = 0.35, *SE* = 0.32, *p* = 0.26, 95% *CI* [-0.27, 0.97]). However, the analysis revealed a significant indirect effect of CSA on ED symptoms through maladaptive CERS (path a1b1; *B* = 0.19, *SE* = 0.07, 95% *CI* [0.06, 0.35]), indicating that maladaptive CERS fully mediates the relationship between CSA and ED symptoms. These findings indicate that maladaptive CERS play a crucial role in explaining the relationship between CSA and ED symptoms. While the direct effect of CSA on ED symptoms is not significant, the significant mediation by maladaptive CERS highlights the importance of considering maladaptive CERS in understanding how CSA contributes to the development of ED symptoms. Consequently, sub-hypothesis 3 is accepted. The model defining the mediating role of maladaptive CERS in the relationship between CSA and the total score of EDs is demonstrated in Figure 4.4

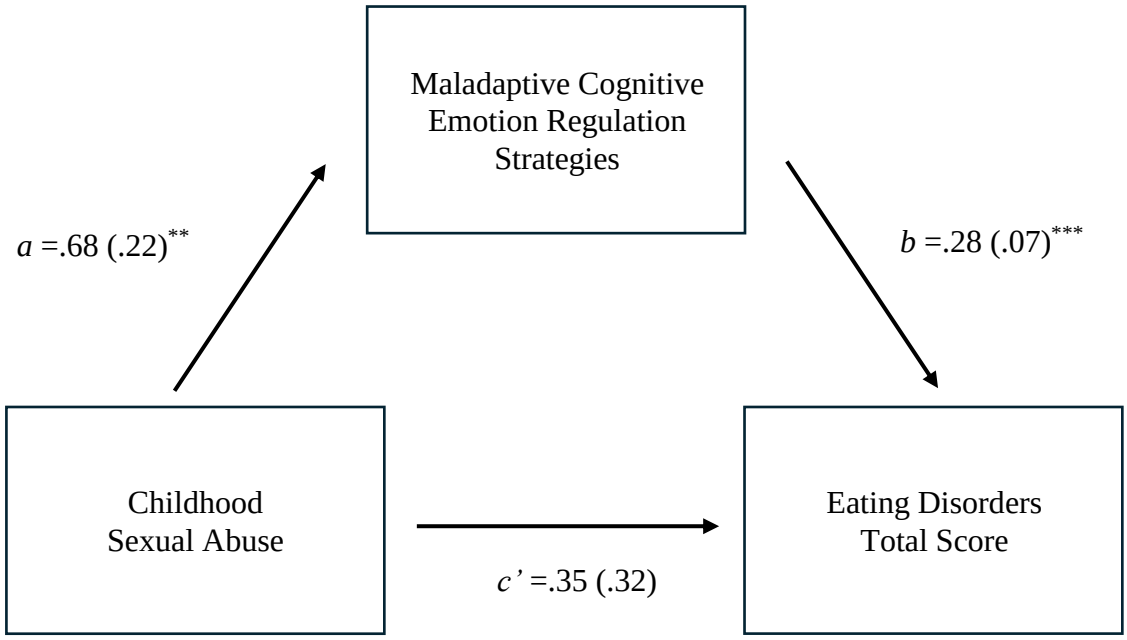


Figure 4.4. The Mediating Role of Maladaptive CERS in the Relationship between Childhood Sexual Abuse and the Total Score of EDs

4.4.1.4. Testing the Sub-Hypothesis 4

The fourth sub-hypothesis stated that *maladaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood physical neglect*** *and eating disorder.*

Therefore, the fifth model represents the associations between CPN and the total score of EDs, including with the role of maladaptive CERS. Based on the findings, it can be said that CPN significantly predicts adopting maladaptive CERS (path a; $B = 0.56$, $SE = 0.22$, $p < 0.05$, 95% *CI* [0.13, 0.99]) and maladaptive CERS significantly predicted the ED score (path b; $B = 0.28$, $SE = 0.07$, $p < 0.001$, 95% *CI* [0.13, 0.42]). CPN showed a significant direct association with ED total score (path c'; $B = 0.60$, $SE = 0.31$, $p < 0.05$, 95% *CI* [0.00, 1.21]).

Mediation analysis revealed that maladaptive CERS significantly and partially mediated this relationship (path a1b1; $B = 0.16$ $SE = 0.07$, 95% *CI* [0.04, 0.30]). This indicates that CPN leads to an increased use of maladaptive CERS, which is, in turn, linked to a greater risk of developing EDs. Consequently, sub-hypothesis 4 is accepted. The model explaining the mediating role of maladaptive CERS in the relationship between CPN and the total score of EDs is demonstrated in Figure 4.5.

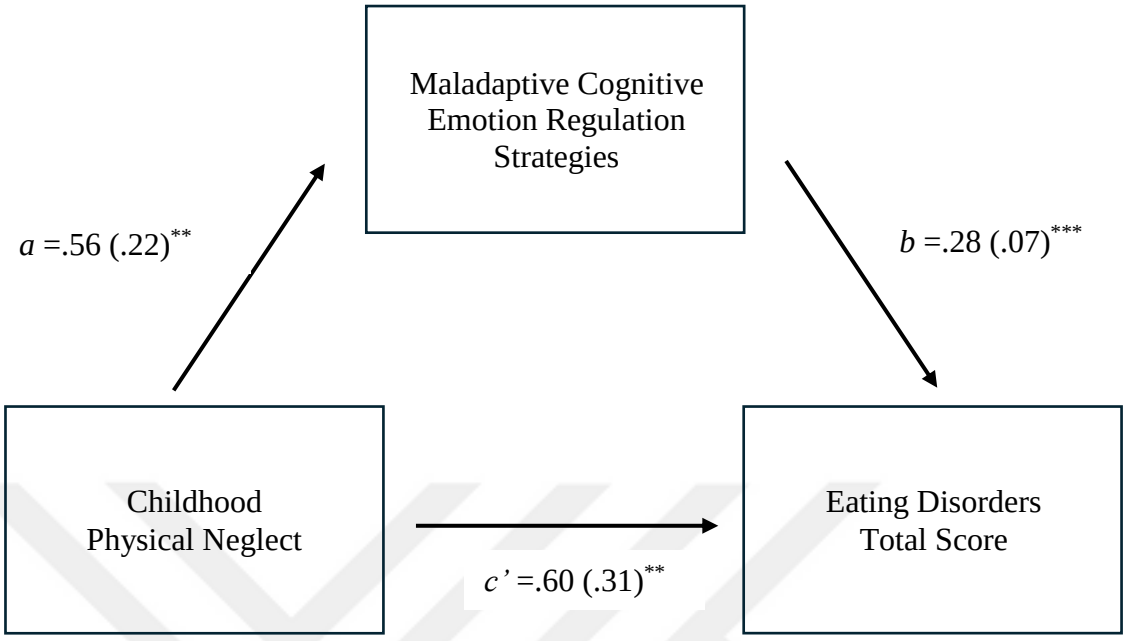


Figure 4.5. The Mediating Role of Maladaptive CERS in the Relationship between Childhood Physical Neglect and the Total Score of EDs

4.4.1.5. Testing the Sub-Hypothesis 5

The fifth sub-hypothesis stated that *maladaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood emotional neglect*** *and eating disorder.*

Thus, the sixth model demonstrates the role of maladaptive CERS in the associations between CEN and the total score of EDs. The results revealed that CEN shows significant associations with maladaptive CERS (path a; B = 0.88, SE = 0.13, $p < 0.001$, 95% CI [0.61, 1.14]) and maladaptive CERS significantly predicted the ED total score (path b; B = 0.25, SE = 0.08, $p < 0.05$, 95% CI [0.10, 0.41]). The presence of maladaptive CERS fully mediated the relationship between CEN and the total score of EDs, with no direct effect of CEN on the total score of EDs (path c'; B = 0.36, SE = 0.21, p = 0.08, 95% CI [-0.047, 0.769]).

Mediation analysis revealed that the indirect effect was statistically significant (*B* = 0.22, *SE* = 0.08, 95% *CI* [0.06, 0.38]), indicating that maladaptive CERS explained the relationship between CEN and the total score of EDs. These findings indicate that maladaptive CERS play a crucial role in explaining the relationship between CEN and ED symptoms. While the direct effect of CEN on ED symptoms is not significant, the significant mediation by maladaptive CERS highlights the importance of considering maladaptive CERS in understanding how CEN contributes to the development of ED symptoms. Consequently, sub-hypothesis 5 is accepted. The model depicting the mediating role of maladaptive CERS in the relationship between CEN and the total score of EDs is demonstrated in Figure 4.6.

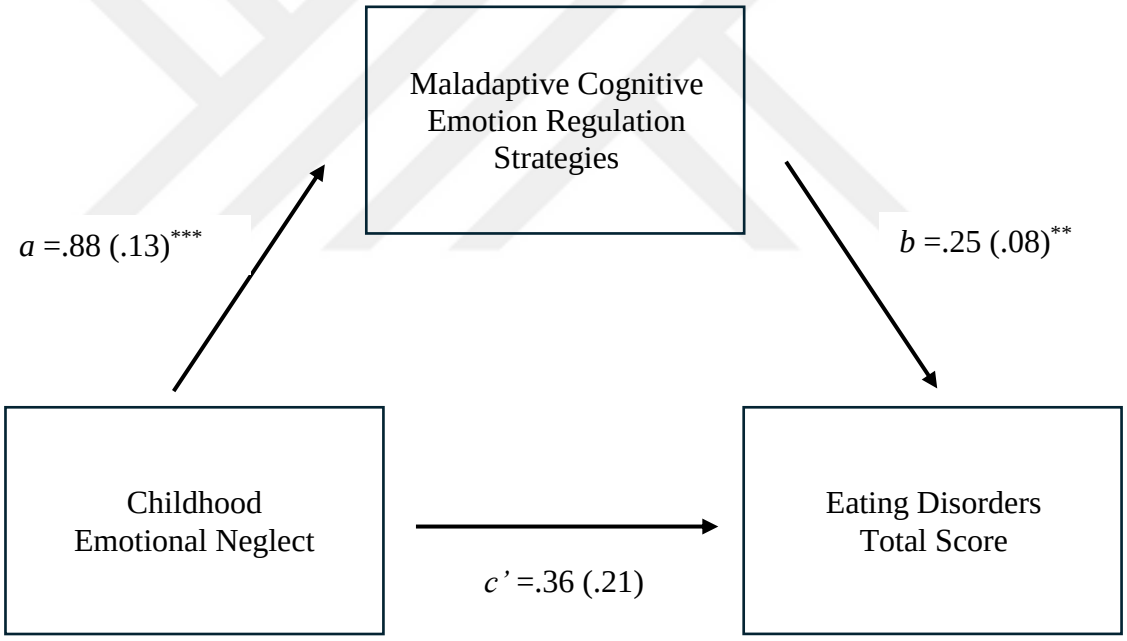


Figure 4.6. The Mediating Role of Maladaptive CERS in the Relationship between Childhood Emotional Neglect and the Total Score of EDs

4.4.1.6. Testing the Sub-Hypothesis 6

The sixth sub-hypothesis stated that *maladaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***parental overprotection-overcontrol*** *and eating disorder.*

The seventh model represents the mediating role of maladaptive CERS in between growing up with OC-OP type of parenting and its relation to developing ED symptomatology. Results demonstrated that OC-OP parenting significantly and very strongly predicted maladaptive CERS (path a; B = 0.96, SE = 0.14, p < 0.001, 95% CI [0.67, 1.22]) and maladaptive CERS significantly predicted the total score of ED (B = 0.24, SE = 0.08, p < 0.05, 95% CI [0.08, 0.39]). The direct relationship between OC-OP and the total ED score was also statistically significant (path c'; B = 0.48, SE = 0.21, p 0.05, 95% CI [0.06, 0.90]). Furthermore, the analysis demonstrated a significant indirect effect of OC-OP on ED symptoms through maladaptive CERS (path a1b1; B = 0.23, SE = 0.08, 95% CI [0.06, 0.39]), indicating partial mediation. This indicates that parental OP-OC leads to an increased use of maladaptive CERS, which is, in turn, linked to a greater risk of developing EDs. Consequently, sub-hypothesis 6 is accepted. Figure 4.7. demonstrates the model representing the mediating role of maladaptive CERS in the relationship between OC-OP parenting and the total score of EDs.

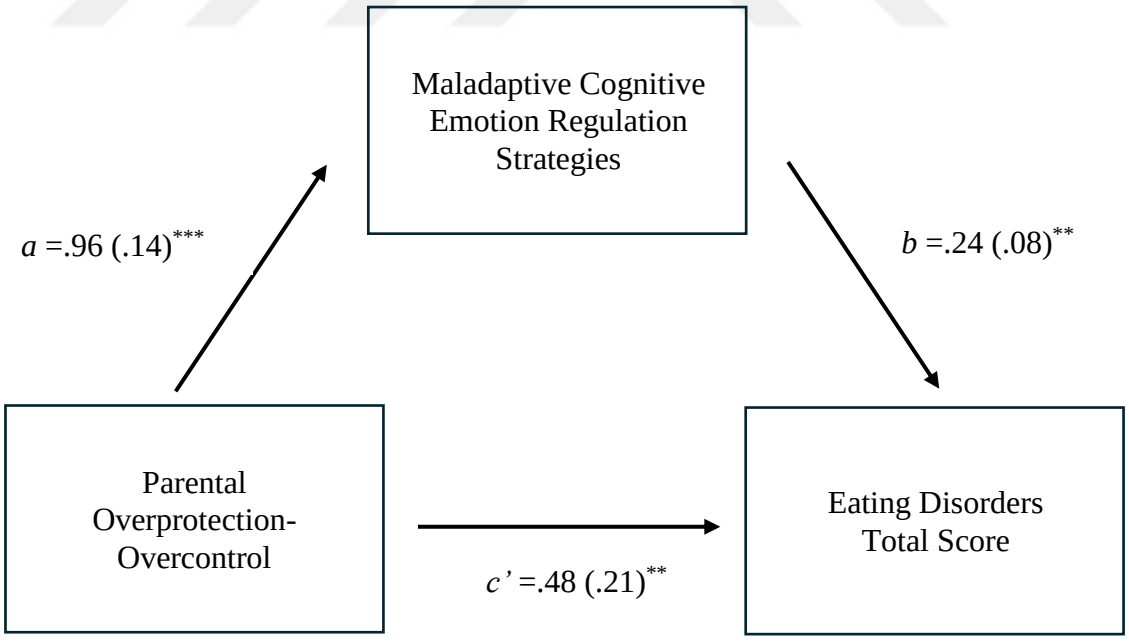


Figure 4.7. The Mediating Role of Maladaptive CERS in the Relationship between Overprotective-Overcontrol Parenting and the Total Score of EDs

4.4.2. Testing the Hypothesis 2

The second hypothesis stated that *adaptive cognitive emotion regulation strategies significantly mediate the relationship between childhood maltreatment and eating disorder.*

Thus, the eighth model tested the mediating role of adaptive CERS in the relationship between the total score of CM and the total score of EDs. The results demonstrated that CM has a negative and significantly predicts adaptive CERS (path a; B = -0.10, SE = 0.03, p = 0.001, 95% CI [-.16, -.04]), while adaptive CERS is not a significant predictor of EDs (path b; B = 0.06, SE = 0.09, p = 0.51, 95% CI [-0.12, 0.24]). The direct effect of CM on EDs is positive and statistically significant (path c'; B = 0.22, SE = 0.06, p < 0.001, 95% CI [0.12, 0.33]). This indicates that higher childhood trauma scores are significantly associated with higher eating disorder symptom severity.

Finally, this model revealed that, unlike maladaptive CERS, adaptive CERS do not bear a mediating role in the relationship between CM and EDs (path a1b1; B = -0.01 95% CI [-0.03, 0.02]). Consequently, hypothesis 2 is rejected. The model defining the relationship between adaptive CERS, the total score of CM, and the total score of EDs is demonstrated in Figure 4.8.

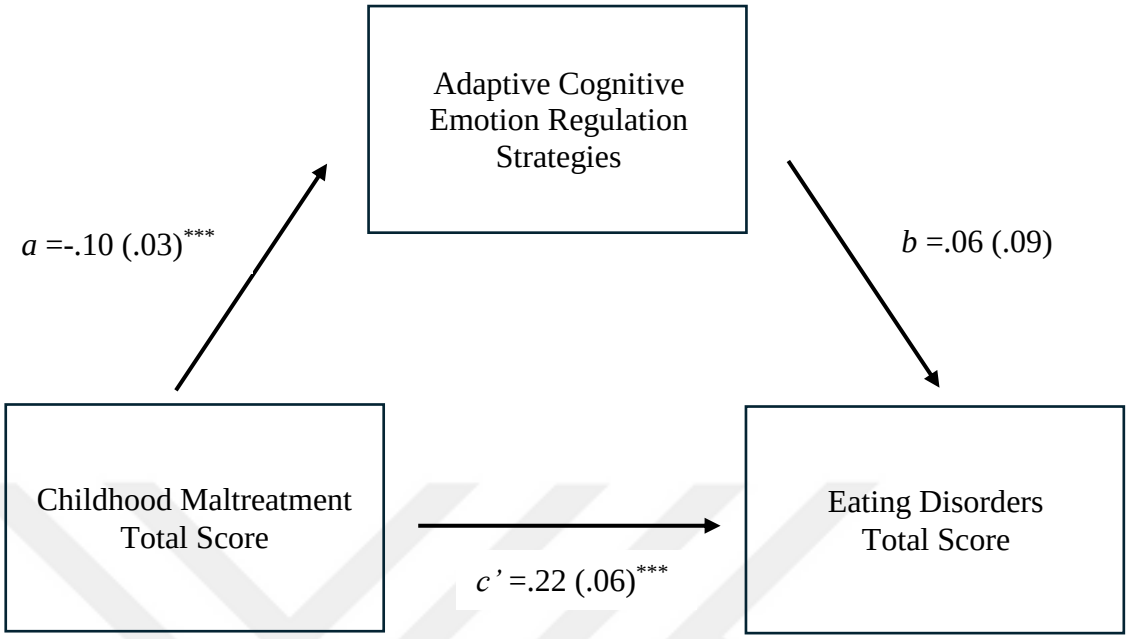


Figure 4.8. The Relationship between Adaptive CERS, the Total Score of Childhood Maltreatment and the Total Score of EDs

4.4.2.1. Testing the Sub-Hypothesis 7

The seventh sub-hypothesis stated that *adaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood physical abuse*** *and eating disorder.*

The ninth model demonstrated the role of adaptive CERS in between CPA and total score of EDs. The results revealed that neither CPA is a significant predictor of adaptive CERS (path a; *B* = -0.14, *SE* = 0.17, *p* = 0.43, 95% CI [-0.47, 0.20]) nor adaptive CERS is a significant predictor of EDs (path b; *B* = 0.01, *SE* = 0.09, *p* = 0.93, 95% *CI* [0.08, 0.39]). However, there is a significant direct relationship between CPA and EDs (path c'; *B* = 0.95, *SE* = 0.30, *p* < 0.05, 95% *CI* [0.35, 1.55]), and adaptive CERS does not bear a statistically significant role between these variables path (a1b1; *B* = -0.00, *SE* = 0.02, 95% *CI* [-0.05, 0.05]).

The mediation analysis shows that adaptive CERS do not mediate the relationship between CPA and ED total score. However, physical abuse directly impacts eating disorder symptoms, indicating that it is a strong predictor. This suggests that factors beyond adaptive CERS may explain how physical abuse affects eating disorder symptoms. Consequently, sub-hypothesis 7 is rejected. The model demonstrating the relationship between adaptive CERS, CPA, and the total score of EDs is demonstrated in Figure 4.9.

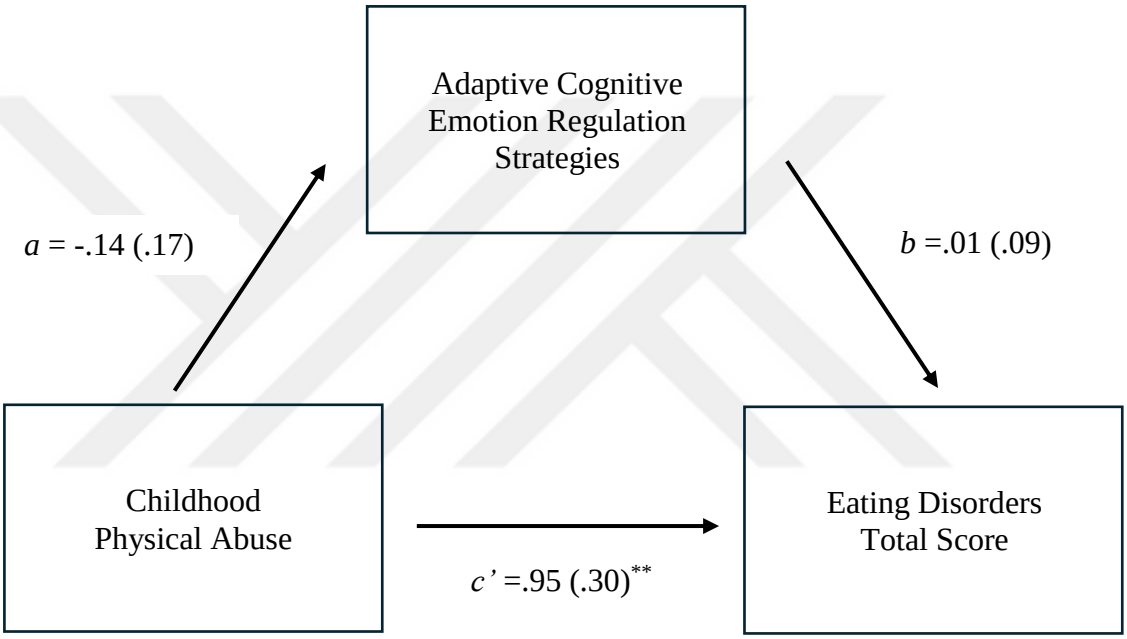


Figure 4.9. The Relationship between Adaptive CERS, Childhood Physical Abuse and the Total Score of EDs

4.4.2.2. Testing the Sub-Hypothesis 8

The eighth sub-hypothesis stated that *adaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood emotional abuse*** *and eating disorder.*

The tenth model represents the influence of CEA on the total score of EDs and the role of adaptive CERS. Based on the results, it was found that there was a negative and significant relation between CEA and adaptive CERS (path a; B = -0.28, SE = 0.12, $p < 0.05$, 95% CI

[-0.52, -0.05]); however, adaptive CERS did not significantly predict the total score of EDs (path b; *B* = .04, *SE* = 0.09, *p* = 0.68, 95% *CI* [-0.14, 0.22]). The direct effect of CEA on EDs was found to be significant, indicating that emotional abuse is a strong predictor of eating disorder symptoms path (c'; *B* = 0.78, *SE* = 0.21, *p* < 0.001, 95% *CI* [0.36, 1.20]). However, the mediation analysis revealed that adaptive CERS did not mediate the relationship between CEA and the total score of EDs (path a1b1; *B* = -.01 *SE* = .03, 95% *CI* [-.08, .05]).

The analysis shows that adaptive CERS do not explain the link between CEA and ED symptomatology. However, CEA has a significant and direct influence on the total score of EDs, meaning that higher levels of CEA are strongly associated with more severe ED symptoms. Consequently, sub-hypothesis 8 is rejected. The relationship between adaptive CERS, CEA, and the total score of EDs is depicted in Figure 4.10.

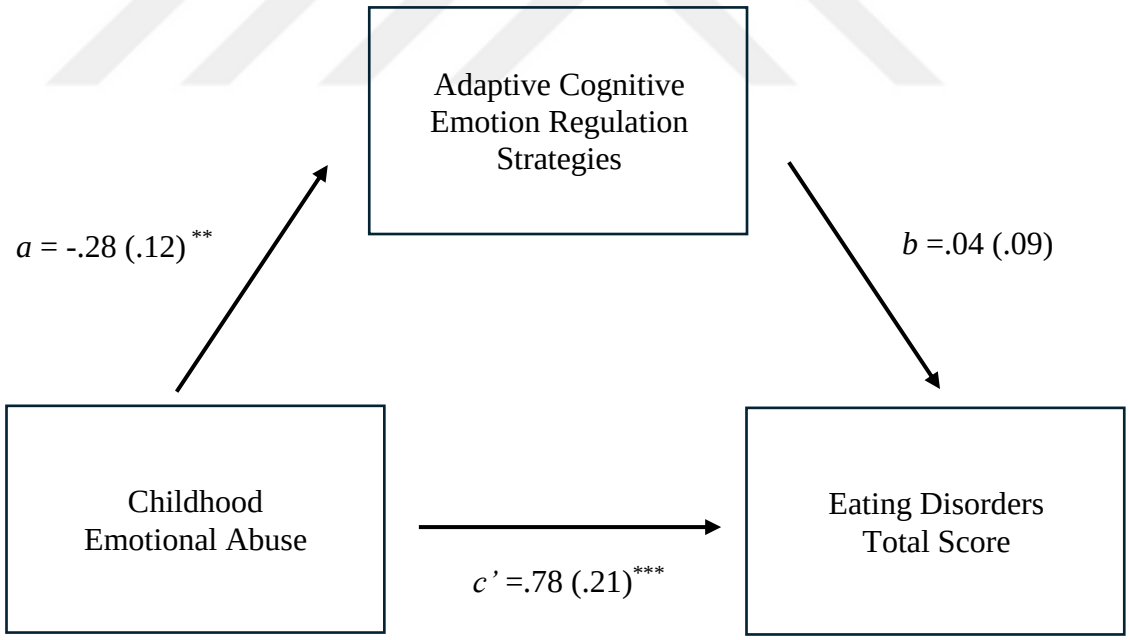


Figure 4.10. The Relationship between Adaptive CERS, Childhood Physical Abuse and the Total Score of EDs

4.4.2.3. Testing the Sub-Hypothesis 9

The ninth sub-hypothesis stated that *adaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood sexual abuse*** *and eating disorder.*

The eleventh model explores the relationship between CSA, adaptive CERS, and EDs. The mediation analysis did not yield any significant findings. Specifically, CSA was not found to be a significant predictor of adaptive CERS (path a; *B* = -0.24, *SE* = 0.17, *p* = 0.17, 95% *CI* [-0.60, 0.10]), and adaptive CERS did not significantly predict ED symptoms (path b; *B* = 0.01, *SE* = 0.10, *p* = 0.93, 95% *CI* [-0.17, 0.19]). Moreover, the direct relationship between CSA and the total ED score was not statistically significant (path c'; *B* = 0.54, *SE* = 0.32, *p* = 0.09, 95% *CI* [-0.08, 1.18]).

There was no evidence supporting a mediating role for adaptive CERS in the relationship between CSA and ED symptoms (path a1b1; B = -0.00, SE = 0.03, 95% CI [-0.07, 0.06]). These findings suggest that neither adaptive CERS nor CSA have a significant direct or indirect impact on the severity of ED symptoms within this model. Consequently, sub-hypothesis 9 is rejected. The model demonstrating the relationship between adaptive CERS, CSA, and the total score of EDs is shown in Figure 4.11.

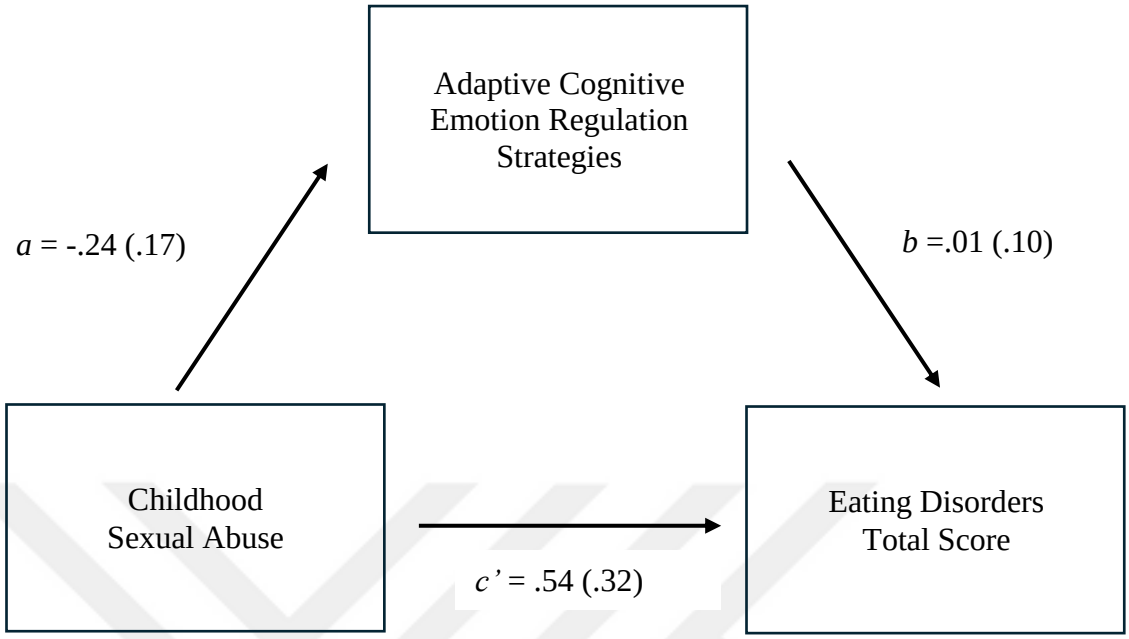


Figure 4.11. The Relationship between Adaptive CERS, Childhood Sexual Abuse and the Total Score of EDs

4.4.2.4. Testing the Sub-Hypothesis 10

The tenth sub-hypothesis stated that *adaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood physical neglect*** *and eating disorder.*

The twelfth model explored the relationship between CPN, adaptive CERS, and eating disorders EDs. The mediation analysis did not yield any significant findings for the mediator. Specifically, CPN was not a significant predictor of adaptive CERS (path a; *B* = -0.26, *SE* = 0.17, *p* = 0.13, 95% *CI* [-0.61, 0.08]), and adaptive CERS was not a significant predictor of ED symptoms (path b; B = 0.01, SE = 0.09, p = 0.88, 95% CI [-0.17, 0.20]). However, the direct relationship between CPN and the total ED score was statistically significant (path c'; *B* = 0.76, *SE* = 0.31, *p* < 0.05, 95% *CI* [0.15, 1.37]). As expected, there was no evidence supporting a mediating role for adaptive CERS in the

relationship between CPN and the total score of EDs (path a1b1; *B* = -0.004, *SE* = 0.03, 95% *CI* [-0.07, 0.06]).

These findings suggest that adaptive cognitive emotion regulation strategies do not mediate the relationship between physical neglect and eating disorder symptoms. However, physical neglect has a direct and significant effect on eating disorder severity in this model. Consequently, sub-hypothesis 10 is rejected. The model representing the relationship between adaptive CERS, CPN, and the total score of EDs is demonstrated in Figure 4.12.

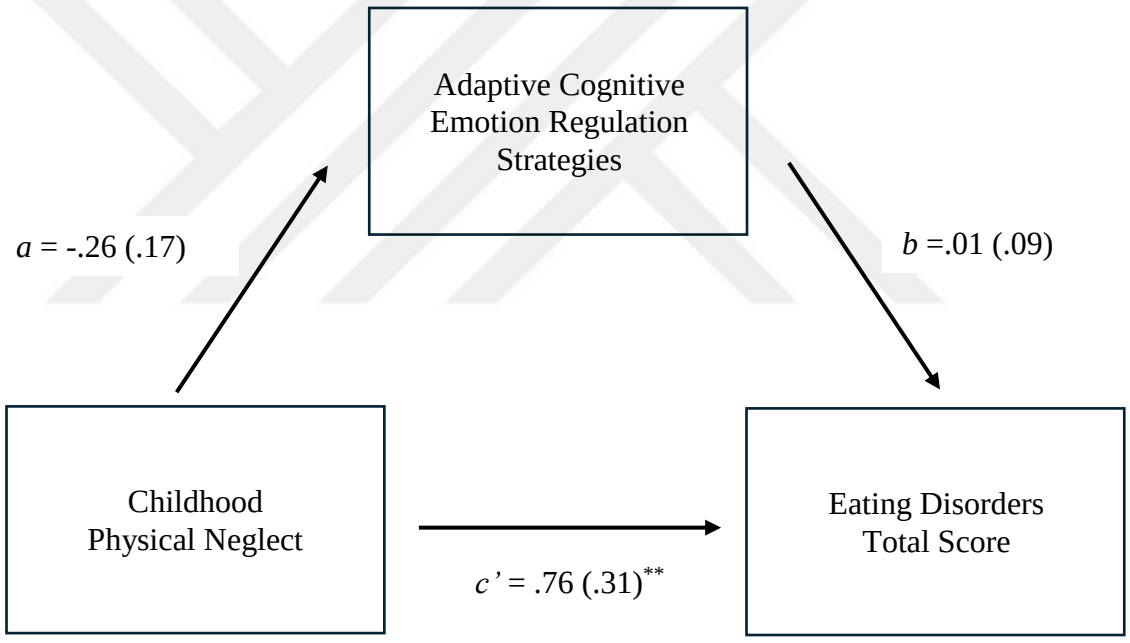


Figure 4.12. The Relationship between Adaptive CERS, Childhood Physical Neglect, and the Total Score of EDs

4.4.2.5. Testing the Sub-Hypothesis 11

The eleventh sub-hypothesis stated that *adaptive cognitive emotion regulation strategies significantly mediate the relationship between* ***childhood emotional neglect*** *and eating disorder.*

The thirteenth model explored the relationship between CEN, adaptive CERS, and EDs. The mediation analysis found that emotional neglect was a significant predictor of adaptive CERS (path a; *B* = -0.50, *SE* = 0.11, $p < 0.001$, 95% *CI* [-0.71, -0.28]), indicating that higher levels of emotional neglect are associated with lower use of adaptive CERS. However, adaptive CERS was not a significant predictor of ED symptoms (path b; *B* = 0.06, *SE* = 0.10, *p* = 0.51, 95% *CI* [-0.13, 0.25]). The direct relationship between emotional neglect and the total ED score was statistically significant (path c'; *B* = 0.61, *SE* = 0.20, $p < 0.05$, 95% *CI* [0.21, 1.02]). As expected, there was no mediating role for adaptive CERS in the relationship between emotional neglect and the total score of EDs (path a1b1; *B* = -0.03, *SE* = 0.05, 95% *CI* [-0.14, 0.07]).

These findings suggest that even though CEN has a direct and significant effect on ED severity in this model, adaptive CERS do not mediate the relationship between CEN and ED symptoms. Therefore, sub-hypothesis 11 is rejected. The model demonstrating the relationship between adaptive CERS, CEN, and the total score of EDs is demonstrated in Figure 4.13.

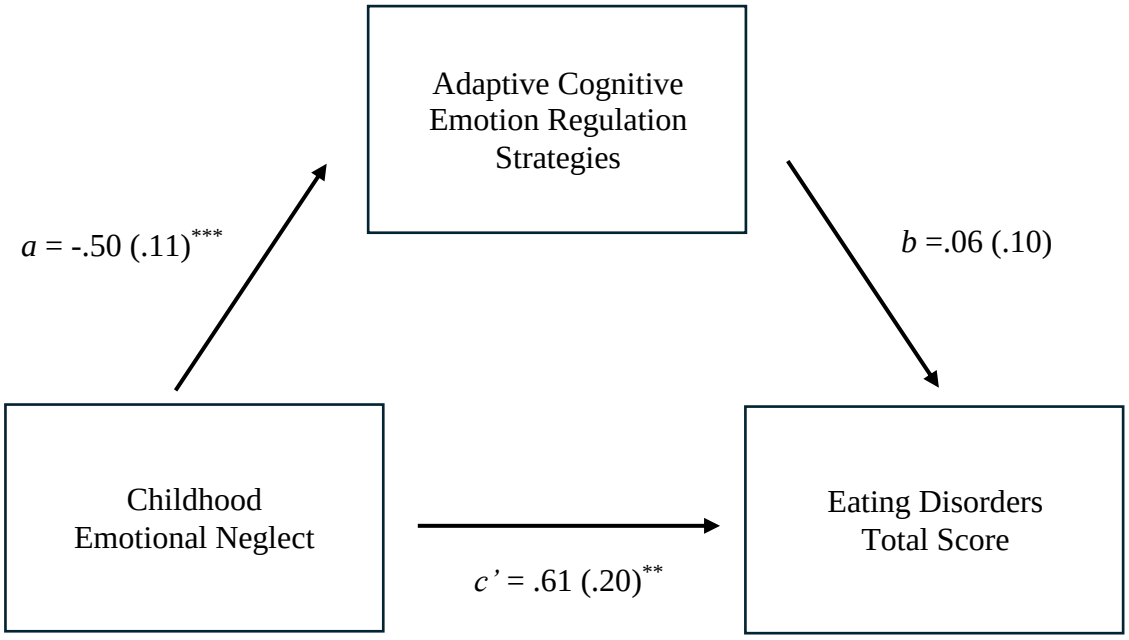


Figure 4.13. The Relationship between Adaptive CERS, Childhood Emotional Neglect, and the Total Score of EDs

4.4.2.6. Testing the Sub-Hypothesis 12

The twelfth hypothesis stated that *adaptive cognitive emotion regulation strategies significantly mediate the relationship between parental overprotection-overcontrol and eating disorder symptomatology.*

The fourteenth model examined the relationship between OC-OP, adaptive CERS, and EDs. The mediation analysis showed that OC-OP was a significant predictor of adaptive CERS (path a; B = -0.37, SE = 0.12, $p < 0.001$, 95% CI [-0.59, -0.14]), suggesting that higher levels of OC-OP are associated with reduced use of adaptive CERS. However, adaptive CERS did not significantly predict ED symptoms (path b; B = 0.05, SE = 0.09, p = 0.58, 95% CI [-0.13, 0.24]). The direct effect of OC-OP parenting on the total ED score was found to be statistically strong and significant (path c'; B = 0.72, SE = 0.21, $p < 0.001$, 95% CI [0.32, 1.13]). However, as expected, there was no evidence to suggest that adaptive CERS mediates the relationship between OC-OP parenting and the total ED score (path a1b1; B = -0.02, SE = 0.04, 95% CI [-0.11, 0.05]).

These results imply that adaptive CERS do not explain the connection between exposure to OC-OP parenting and ED symptoms. Consequently, sub-hypothesis 12 is rejected. The model demonstrating the relationship between adaptive CERS, OC-OP parenting, and the total score of EDs is shown in Figure 4.14.

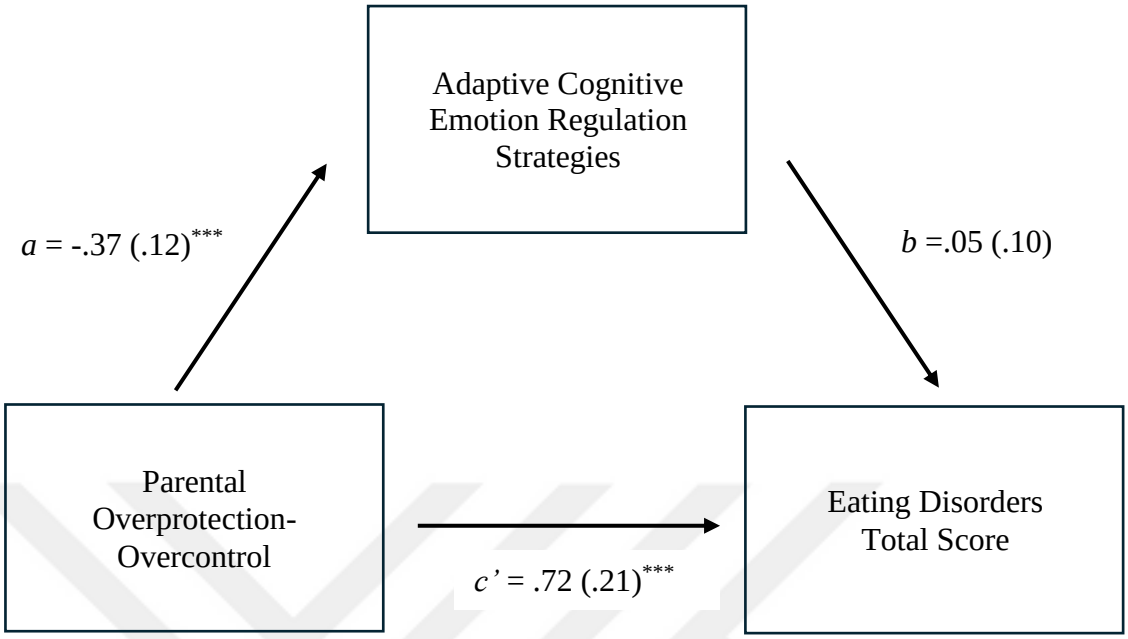


Figure 4.14. The Relationship between Adaptive CERS, Overprotective-Overcontrol Parenting, and the Total Score of EDs

The results of the mediation analysis indicate that maladaptive CERS play a mediating role in the association between each type of CM and the symptomatology of eating disorders (ED). Each pathway was examined, revealing that in most cases, CM demonstrated strong and statistically significant direct associations with ED symptomatology, with the exception of sexual abuse and emotional neglect. In these specific types of maltreatment, no significant direct relationship with ED symptomatology was observed.

However, it is essential to note that each type of CM emerged as a significant and robust predictor of adopting maladaptive CERS. Maladaptive CERS, in turn, was found to be a significant predictor of ED scores, though with a low to moderate level of association. Furthermore, maladaptive CERS were revealed to partially mediate the relationship between maltreatment and ED symptomatology in cases of physical abuse, emotional abuse, physical neglect, and over-controlling or over-protective parenting. In contrast,

maladaptive CERS were shown to fully mediate the relationship in cases of sexual abuse and emotional neglect.

The results of the mediation analyses using adaptive CERS indicate that it does not act as a mediating factor between any form of CM and the overall score of EDs. Notably, adaptive CERS did not exhibit any significant associations with EDs, in any model. Although it was found to be in accordance with the total score of CM and certain types of CM such as emotional abuse, emotional neglect, and OC-OP parenting, adaptive CERS did not demonstrate any significant associations with physical abuse, physical neglect, and sexual abuse. Nevertheless, with the exception of sexual abuse, each type of CM displayed substantial and significant direct relationships with ED symptomatology.

CHAPTER V

DISCUSSION

The main aim of this research was to explore the mediating role of cognitive emotion regulation strategies (CERS) in the relationship between childhood maltreatment (CM) and the total score of eating disorders (EDs) among the general population in Turkiye. More explicitly, this study examined the mediating role of adaptive and maladaptive CERS in the relationship between different types of CM and the total score of EDs. To achieve this aim, fourteen models were developed and analyzed using mediation analysis. The first seven models examined the mediating role of maladaptive CERS in the relationship between various types of trauma (physical, sexual, emotional abuse, and physical and emotional neglect), including the total score of CM and total ED symptom scores. Then, the last seven models were designed to investigate the role of adaptive CERS. Results revealed that while adaptive CERS do not have a mediating role between any CM and EDs, maladaptive CERS significantly mediated the relationship between all types of CM and EDs. In fact, maladaptive CERS fully mediate the relationship of sexual abuse and emotional neglect with EDs. This chapter aims to critically examine the findings of the study in the context of existing literature. It begins by elucidating the roles of adaptive and adaptive CERS), subsequently interpreting the findings through the lens of McLaughlin's theoretical model. Furthermore, this chapter addresses the study's limitations, explores future implications, and highlights the strengths of the research.

5.1. The Role of Maladaptive Cognitive Emotion Regulation Strategies

In this study, maladaptive CERS is defined by summing the scores of self-blame, rumination, acceptance, catastrophizing, and blaming others. A series of mediation analyses were conducted to elucidate the mediating role of maladaptive CERS in the relationship between the types of CM and the overall score of EDs. The results of these

analyses indicated that maladaptive CERS effectively mediate the associations between all forms of CM, including the total score of CM, and EDs. Notably, the mediation effects varied across different models. Specifically, maladaptive CERS was found to fully mediate the relationship between childhood sexual abuse (CSA) and childhood emotional neglect (CEN) with total ED scores, while it partially mediated the relationships for the total CM score, childhood physical abuse (CPA), childhood emotional abuse (CEA), childhood physical neglect (CPN), and parental overprotection and overcontrol (OP-OC). The following paragraphs discuss these findings.

Prior to exploring the findings of the mediation analysis, it is required to provide the rationale for considering the acceptance subscale within the context of maladaptive CERS. As highlighted in the Literature Review and Results chapters, acceptance is often seen as an adaptive strategy. However, the literature shows that it is associated with both positive and negative consequences, depending on the type of acceptance being used. Acceptance has shown to be an effective approach in psychotherapies like Acceptance and Commitment Therapy (ACT) (Hayes et al., 2006), which has gained recognition for its significant results in the field (Hulbert-Williams & Hulbert-Williams, 2022). Conversely, certain forms of acceptance, such as passive acceptance (Pretorius et al., 2010) and resigned acceptance (Duncanson et al., 2022; van Beugen et al., 2017) are associated with diminished well-being and heightened psychological complications, such as depression and anxiety (Martin & Dahlen, 2005). The acceptance subscale of the CERQ (Garnefski & Kraaij, 2007), by definition, assesses individuals' thoughts on accepting their experiences and resigning themselves to what has happened, which suggests that it is assessing a maladaptive form of acceptance because adaptive acceptance involves acknowledging and embracing one's thoughts and feelings non-judgmentally, enabling fuller engagement with experiences instead of avoidance or suppression (Kober et al., 2019; Messina et al., 2021). The findings of Tuna and Bozo (2012) support this claim. They adapted the scale to Turkish and discovered that the acceptance scale shows positive associations with other established maladaptive CERS and psychological issues like depression, anxiety, negative self-concept, and hostility while also showing a negative correlation with self-efficacy. The current study also found that the acceptance subscale

of CERQ shows significant positive correlations with maladaptive strategies, namely, self-blame, rumination, catastrophizing, and blaming others. These findings signify that the acceptance subscale of CERQ does not assess an adaptive form of acceptance. Therefore, it was decided to consider it among the maladaptive CERS.

The findings from mediation analysis revealed that the total score of CM was significantly associated with maladaptive CERS, and maladaptive CERS, in turn, showed positive and significant associations with the total score of EDs. Additionally, a significant direct relationship between the total score of CM and the total score of EDs was observed. Therefore, it's concluded that maladaptive CERS partially mediate the relationship between CM and EDs. This finding is evidence of the literature that suggests traumatic childhood experiences, including maltreatment, are related to EDs, and it is often mediated by emotion dysregulation (Trottier & MacDonald, 2017b). Nevertheless, the mediating role of maladaptive CERS was the least pronounced in this model compared to types of CM. Consequently, models that specifically concentrate on each type of CM have provided more detailed information to comprehend the relationship between CM, the total score of EDs, and the mediating role of the use of maladaptive CERS.

A mediation analysis conducted to discover the relationship between CEN and the total score of EDs revealed that CEN, the maltreatment reported by nearly half of the participants (49.7%) demonstrated a moderate and significant association with maladaptive CERS and maladaptive CERS showed significant relations with the total score of EDs. Nonetheless, CEN did not exhibit any direct relation with ED scores. Instead, the association between CEN and ED symptomatology was fully mediated by maladaptive CERS. Specifically, the mediation analysis revealed that the influence of CEN on the total score of EDs operates entirely through maladaptive CERS, as no direct effect of CEN on ED symptoms was observed. These findings demonstrate that maladaptive CERS potentially plays a central role in the relationship between CEN and EDs.

As previously mentioned, the existing literature does not provide a comprehensive examination of the relationship between CEN and EDs. Nevertheless, several studies have identified significant associations between these two variables. For instance, Emery et al. (2021) demonstrated that CEN, among various forms of childhood maltreatment, serves as a prominent risk factor for the development of EDs. Similarly, Gioia et al. (2022) found that CEN strongly predicts EDs. Brustenghi et al. (2019) conducted a study with a limited sample of ED patients (N = 40) and reported that emotional neglect exhibited the strongest correlation with EDs compared to other forms of maltreatment. Furthermore, O'Loghlen et al. (2023) indicated a significant association between CEN and binge eating behaviors, partially mediated by internal shame and psychological distress. Additionally, prior to this study, Vajda and Láng (2014) demonstrated CEN significantly predicts EDs and claimed that difficulties in emotion regulation potentially mediate this relationship. In the current study, however, although correlation results indicate a relationship between CEN and the total score of EDs, mediation analysis revealed no direct link between CEN and EDs; instead, the relationship appears to operate only through maladaptive CERS. These findings underscore the complexity of the relationship between CEN and EDs, suggesting that CEN may not necessarily be a direct risk factor for EDs. This perspective aligns with the work of Kimber et al. (2017), which highlighted that existing studies have not determined whether the relationship between CEN and EDs indicates specific or non-specific risk factors for ED development. By referring to the work of Moulton et al. (2015) and Racine and Wildes (2015), who claimed that difficulties in emotion regulation could significantly mediate the link between CM and EDs, Kimber et al. (2017), argue that underlying emotion regulation challenges often stem from CM, including CEN. By adversely affecting emotional regulation processes, they foster unhealthy eating patterns in dealing with emotions. Consequently, while CEN may not be a specific risk factor for EDs, it can contribute to their emergence by distorting emotional regulation processes. Moreover, Musetti et al. (2023) emphasized that CEN is a critical predictor of attachment insecurities, which can exacerbate maladaptive emotional regulation strategies and contribute to the onset of EDs. This underscores that CEN can serve as an indirect risk factor for EDs.

Additionally, it is well established that a substantial proportion of ED patients have histories of childhood maltreatment (Smolak & Murnen, 2002). For example, in clinical samples, emotional neglect was reported by 68% of patients with EDs (Becker & Grilo, 2011). However, as Afifi et al. (2017) highlight, such clinical data are limited, as they primarily include the most severe cases of EDs and CM experiences. In other words, the absence of a direct relationship can be attributed to the characteristics of the research population, which consisted of individuals from the general population rather than a clinical setting. Another important factor could be the sociocultural factors.

Mediation analysis for CSA yielded findings similar to those observed in CEN. Specifically, while CSA did not exert a direct effect on ED symptoms, maladaptive CERS significantly mediated the relationship between the two. In other words, maladaptive CERS fully mediated the relationship between CSA and EDs. This finding illuminates the pivotal role of maladaptive CERS in elucidating the association between CSA and ED symptoms. Likewise, previous research examining the mediating role of intrusive thoughts—a type of maladaptive CERS—between CM and EDs revealed that these thoughts strengthened the relationship between CSA and ED (Dawson et al., 2022). Tilstra-Ferrell et al. (2023) demonstrated that a lack of emotional clarity, which is an emotion regulation difficulty, mediates the link between CSA and emotional eating, a disordered eating pattern. Consequently, it is evident that the findings of the current study contribute to the literature by providing further evidence for this triadic relationship involving maladaptive CERS as a mediator between CSA and EDs.

However, the absence of a direct relationship between CSA and the overall ED score is surprising and contradicts a substantial body of existing research. For instance, Afifi et al. (2017) established that childhood emotional abuse (CEA) and CSA are particularly associated with EDs. Moreover, pronounced associations have been identified between CSA and anorexia nervosa (AN) (Talmon & Widom, 2022) as well as binge eating disorder (BED) (Grilo & Udo, 2021; O'Loghlen et al., 2023). A meta-analysis by Caslini et al. (2016) illuminated the significant relationships between CSA and AN, BN, and

BED. Additionally, as shown by Kovács-Tóth et al. (2022), individuals with a history of CSA are approximately 11 times more likely to be at risk for EDs.

Despite the mediation analysis indicating a connection through maladaptive CERS, given the extensive literature highlighting the critical findings suggesting the link between CSA and EDs, it is puzzling that this study does not reveal a direct association between CSA and EDs. However, this is not the only instance. For example, in their relatively early study, Burns et al. (2012) found that CSA was not a significant predictor of EDs when controlling for CEA. Their findings show that CSA did not significantly predict EDs when controlling for CEA. They suggest that the co-occurrence of CSA with other types of abuse (e.g., CEA or CPA) might explain the observed correlations between CSA and ED symptoms. This interpretation implies that previous studies may have reported inflated associations between CSA and EDs due to the omission of CEA as a factor. Additionally, they pointed out the CSA items in the CTQ (the extended version of it utilized in the current study), particularly the extended version used in this study, have limitations due to their focus on frequency rather than severity. They explained that this approach may fail to capture the significant impact of less frequent yet harmful CSA incidents, leading some individuals not to report their experiences and thereby skewing the results. Additionally, the researchers highlighted that individuals often do not identify their experiences using terms such as “molested” or “sexually abused” as presented in the scale, and they may even deny or fail to acknowledge such experiences, which could further contribute to underreporting (Bondurant, 2001). The same issue was highlighted by a study conducted in China (H. Li et al., 2024) and explained its findings regarding the absence of a correlation between CSA and EDs, positing that individuals may be hesitant to disclose their experiences of sexual abuse. It further suggests that the nuances of these experiences may not be adequately captured by the items in the questionnaire. These observations may also provide insights into the current study's findings. More specifically, due to the low representation of individuals with a history of CSA, as the possible reasons previously outlined, a direct relationship may not be evident. Nonetheless, this finding is significant for understanding the role of maladaptive CERS, even within this small number of representatives.

Mediation analysis conducted to examine the mediating role of maladaptive CERS in the relationship between childhood emotional abuse (CEA) and the total score of EDs revealed that maladaptive CERS partially mediate the relationship between CEA and EDs. This indicates that CEA contributes both directly and indirectly, via maladaptive CERS, to the manifestation of ED symptoms. It is already well-documented by numerous studies (e.g., Akgöz Aktaş et al., 2023; Caslini et al., 2016; Friedman et al., 2023; Vajda & Láng, 2014) that CEA has a significant impact on the development of EDs. However, there is currently insufficient evidence regarding the indirect impact of CEA through maladaptive CERS. Despite limited research on the indirect impact of CEA on EDs through maladaptive CERS, existing literature on emotion regulation difficulties provides consistent results. For example, a study mentioned above by Burns et al. (2012) draws attention to the fact that researchers, until that time, did not give enough recognition to CEA. However, their findings showed that CEA is significantly related to EDs; in fact, it was found to be consistently associated with EDs compared to CSA and CPA. Further, they highlighted that emotion dysregulation partially mediated the link between CEA and symptoms of EDs. Additionally, Racine and Wildes (2015) highlighted the significant mediating role of emotion regulation difficulties in this context. The current study contributes to existing research by showing how habitual use of maladaptive cognitive strategies for emotion regulation, such as catastrophizing, ruminating, self-blaming, or blaming others, can link CEA to the development of ED symptoms.

The mediation analysis conducted to evaluate the role of maladaptive CERS in the relationship between childhood physical neglect (CPN) and EDs revealed that maladaptive CERS significantly mediate the association between CPN and the total score of EDs. Furthermore, a direct significant relationship exists between CPN and EDs. These findings suggest that maladaptive CERS partially mediate the connection between CPN and the total score of EDs. The direct significant relationship observed between CPN and EDs corroborates previous research (Afifi et al., 2017; Gioia et al., 2022; Kimber et al., 2020; Minnich et al., 2017). Nevertheless, there is a paucity of evidence regarding the influence of emotion regulation within this relationship. The results of this study imply

that the deployment of maladaptive cognitive strategies for emotional regulation partially elucidates the link between CPN and the total score of EDs.

The present study investigates the mediating role of maladaptive CERS in the relationship between childhood physical abuse (CPA) and the overall score of EDs. The findings demonstrate that CPA is significantly associated with the total score of EDs both directly and indirectly through maladaptive CERS. Numerous existing studies have examined the connection between CPA and EDs, indicating that CPA is a significant predictor of EDs, thereby corroborating the results of the current research (Afifi et al., 2017; Caslini et al., 2016; Kovács-Tóth et al., 2022; Talmon & Widom, 2022). Furthermore, CPA has been shown to intensify the severity of ED symptoms (Borg et al., 2022). However, prior research has often failed to elucidate the mechanisms through which emotion regulation connects CPA to EDs. This study provides new insights into the relationship among CPA, emotion regulation, and EDs by demonstrating that CPA is associated with the employment of maladaptive CERS, which in turn is linked to the total score of EDs.

The parental overprotection-overcontrol (OP-OC) dimension was initially introduced by Şar et al. (2021) in the trauma questionnaire for the Turkish population due to its widespread occurrence in Turkish society and its detrimental effects on individuals raised in such environments. Supporting this claim, the mediation analysis in the current study indicated that parental OP-OC associates with maladaptive CERS, which are further related to elevated total scores of EDs. Moreover, there is a significant direct link between OP-OC and EDs, suggesting that maladaptive CERS significantly and partially mediate the relationship between OP-OC and EDs. Recently, numerous studies have explored the relationship between parental OP-OC and its influence on the emergence of ED symptoms. These investigations, consistent with the findings of this study, imply that OP-OC contributes to the onset of ED symptoms (Gruber et al., 2020; Hampshire et al., 2022; Usmani et al., 2022). Although there is a gap in the literature regarding the role of maladaptive CERS, Iqbal et al. (2023) investigated the influence of emotion regulation difficulties. Their findings indicate a significant mediating role of these difficulties in the relationship between maternal overprotection and eating-related problems, aligning with

the present study. However, further research is necessary to examine the mediating role of emotion regulation in the context of childhood maltreatment and EDs.

5.2. The Role of Adaptive Cognitive Emotion Regulation Strategies

In the present study, adaptive CERS encompass techniques that refocus on planning, positive refocusing, positive reappraisal, and putting into perspective. A series of mediation analyses were conducted to explore the mediating role of adaptive CERS in the relationship between all types of CM and the overall score of EDs. The results from these analyses indicated that adaptive CERS do not mediate the relationship between any type of CM, including the total scores of CM and EDs. This finding stands in contrast to the conclusions drawn by Dawson et al. (2022), which demonstrated that cognitive reappraisal, a form of adaptive CERS, negatively mediates the relationship between CEN and EDs. The observed discrepancy may be attributable to methodological differences, as the assessment questionnaires for emotion regulation and eating disorders utilized in their study were distinct from the current study's. Furthermore, this study assessed the collective effect of four adaptive CERS; however, there may be differences between individual adaptive CERS in terms of occurring as a mediator.

The mediating effect was not observed because there was no significant relationship between adaptive CERS and the total ED score. This suggests that adaptive CERS did not significantly relate to EDs based on the data of the current study. These results contradict a meta-analysis conducted by Prefit et al. (2019), which identified strong negative correlations between EDs and adaptive emotion regulation strategies, including emotional awareness, clarity, adaptive acceptance, reappraisal, and problem-solving. Nevertheless, Aldao & Nolen-Hoeksema (2010) showed that adaptive CERS, like reappraisal and problem-solving, show less association with EDs compared to maladaptive CERS, such as rumination and thought suppression. Thus, it can be concluded that the evidence regarding the relationship between adaptive emotion regulation strategies and EDs remains mixed.

Even though adaptive CERS had no mediating role, its relationship with specific types of CM is noteworthy. Specifically, while CSA, CPA, and CPN did not demonstrate significant relationships with adaptive CERS, CEN, CEA, and parental OP-OC exhibited significant negative associations with adaptive CERS. It is important to note that Zweig-Frank and Paris (1991) have proposed that parental OP-OC may be regarded as a form of emotional maltreatment due to its strong correlation with various types of emotional maltreatment. Collectively, these findings suggest that, although other forms of maltreatment do not exhibit a significant relationship, emotion-related maltreatment types demonstrate negative associations with adaptive emotion regulation processes. Consequently, it can be inferred that individuals exposed to emotion-related maltreatment are, in turn, less likely to engage in adaptive CERS. Numerous neurological studies support this claim and the findings of the current research. A systematic review conducted by Cassiers et al. (2018) that examined the relationships between functional and structural brain abnormalities and various types of CM revealed that types of emotional maltreatment uniquely affect the brain's emotion-regulation network. The review highlighted specific alterations in connectivity between the amygdala, medial prefrontal cortex (mPFC), and anterior cingulate cortex (ACC), which are critical for emotion regulation. Abnormalities in these areas are also found to be related to less adoption of adaptive emotion regulation strategies (Zhou et al., 2024). Furthermore, parental overcontrol is linked to increased connectivity in networks for threat detection and top-down regulation—where the brain manages emotions through conscious thinking—potentially heightening sensitivity to threats and limiting adaptive emotion regulation (Carbone et al., 2024). These results underscore the meaningful association between emotion-related maltreatment and reduced use of adaptive CERS.

5.3. Interpreting Findings from the Perspective of Theoretical Framework

The current study was developed based on McLaughlin et al.’s transdiagnostic developmental model (2020). This model argues that exposure to maltreating behaviors during childhood impacts significant mechanisms within the individual, namely social processing, emotion processing, and acceleration in biological aging, which in turn lead

to various psychopathologies. In other words, these mechanisms are crucial for understanding the relationship between CM and psychological disorders. Because these traumatic events and distortions or alterations in the significant mechanisms work as underlying mechanisms for many psychopathologies, these factors are considered to have transdiagnostic features. In this study, the ED symptoms were investigated as the psychopathology in the model. In line with McLaughlin et al.'s model, among various possible childhood traumas, CM was the focus. Finally, the roles of adaptive and maladaptive CERS were tested to determine whether they mediated the relationship between CM and EDs. Based on the results, adaptive CERS and maladaptive CERS provided distinct pictures with new insights into understanding the interplay between emotion-related processes, childhood maltreatment, and a cluster of psychopathologies, namely EDs.

Maladaptive CERS were found to be significantly associated with exposure to all types of CM. This study demonstrates that all forms of CM are significantly associated with the employment of maladaptive cognitive strategies to regulate emotions. This finding underscores the tendency of individuals with a history of CM to use maladaptive CERS in response to stressors. These findings compellingly support McLaughlin et al.'s model, which posits that CM impacts emotion processing. Therefore, consistent with the model's intent, this study's results clearly indicate that individuals with a history of CM tend to adopt maladaptive CERS during stressful situations. Maladaptive CERS, in turn, has significant associations with the psychological disorder chosen for the current study, namely EDs. More significantly, maladaptive CERS, as the model suggests, showed a significant mediating role between all types of CM and the total score of EDs. In fact, it fully mediated the effects of CSA and CEN on the total score of EDs. These findings support McLaughlin et al.'s transdiagnostic developmental model, emphasizing the relevance of emotion regulation processes, particularly the use of maladaptive strategies, in understanding the complex associations between CM and ED psychopathology.

Adaptive CERS demonstrated unique patterns in relation to CM. Specifically, adaptive CERS were significantly and negatively associated with CEN, CEA, and parental OP-OC,

yet showed no relationship with other CM forms and were not linked to ED psychopathology. Despite the significant associations between all CM forms, excluding CSA, and ED symptoms, adaptive CERS did not mediate any of these relationships. The association between CM and adaptive CERS suggests that emotion-related maltreatment types, particularly CEN, CEA, and parental OP-OC, may correspond with diminished adaptive emotional processing. Even though the model does not specifically articulate such a negative impact of utilizing adaptive strategies, the focus is on difficulty or disruption in emotional processing; this study contributes to the literature by providing empirical evidence regarding the adverse effects of childhood emotion-related maltreatment on the adoption of adaptive CERS. Nevertheless, concerning the mediating role, adopting adaptive cognitive strategies does not have a significant influence on the case of EDs in the general population of the current study. Further investigation of the clinical population can provide a detailed understanding of this issue.

5.4. Limitations

The cross-sectional design represents a primary limitation of this study, as it restricts the ability to draw causal inferences between CM, CERS, and EDs due to its single-point data collection approach. This design was chosen as a consequence of practical constraints, such as limited time and resources, as it facilitates data gathering and efficient data analysis in a short period of time. However, it provides information and preliminary insights into the interplay between these variables by addressing the gaps in the literature and provides a direction for future longitudinal or experimental research to clarify causation.

The sample consists of 352 individuals, a figure sufficient for conducting the study; however, it does not adequately represent the diversity of the broader Turkish society. Specifically, the sample size and characteristics contribute to a lack of heterogeneity within the participant group, which ultimately restricts the study's generalizability to a broader population. Importantly, the gender distribution among participants was notably unequal, with a disproportionately higher number of female respondents. Additionally,

the average age of participants was 29.55 years, with only 3.4% aged 50 or older, indicating that older age groups are underrepresented, which can significantly limit the applicability of the findings across different age groups. However, given that existing literature shows EDs to be more prevalent among young women, this specific sample composition may actually be functional, offering valuable insights into the dynamics of EDs within this high-risk demographic.

Another limitation is the scale used to assess eating disorders. EDE-Q-13 is a short form of a widely utilized assessment tool (Lev-Ari et al., 2021). However, the item number of some of its subscales was less than two, which restricted the ability to make an adequate assessment based on the symptomatology. A significant limitation pertains to the scale employed in evaluating eating disorders. Despite this, since the study focused on the total score for eating disorders and aimed to comprehend the scores in relation to CM and CERS, this limitation did not adversely affect the study's results.

5.5. Future Implications

Given the findings from this research, it is crucial to examine the future implications, especially regarding the evaluation of the roles of each CERS. This evaluation will help pinpoint key strategies that play a critical function in the relationship between CM and EDs. Furthermore, it is recommended that future studies conduct symptom-level investigations to elucidate the specific forms of CM's influence on the symptoms and to clarify the role of different CERS beyond the classification of adaptive or maladaptive.
More research should be conducted on the mediating role of emotion regulation in the relationship between types of CM and EDs. The literature is especially scarce in the case of childhood neglect and parental OP-OC. More studies are needed to gain a better understanding of this interplay.

Integrating mixed-method designs could offer a more nuanced understanding of the relationship between CM and EDs. For instance, qualitative interviews alongside quantitative measures may uncover subjective experiences of maltreatment and the

perceived effectiveness of various emotion regulation strategies. These insights could help identify the contextual factors influencing the development of ED symptomatology and inform tailored interventions. Exploring patients' lived experiences with adaptive and maladaptive CERS could also highlight barriers to effective emotion regulation.

Future research should adopt longitudinal designs to examine the dynamics between CM, EDs, and CERS over time. Such designs could reveal how less use of adaptive strategies and reliance on maladaptive strategies develop and change throughout critical periods, offering a clearer picture of their relationships with ED symptoms. By tracking participants across multiple time points, longitudinal studies can also help identify early predictors of EDs among individuals with a history of specific types of CM, such as neglect or emotional abuse. These insights would not only enhance our understanding of how emotion regulation evolves but also inform the timing and focus of targeted interventions aimed at mitigating risk factors and fostering resilience.

Experimental designs, such as randomized controlled trials, could explore the efficacy of interventions aimed at enhancing adaptive CERS. For example, targeted interventions could test whether teaching adaptive strategies like cognitive reappraisal reduces disordered eating behaviors in individuals with a history of CM or if they are irrelevant in terms of their impact on EDs. Additionally, experiments could examine the direct impact of training in specific emotion regulation strategies on reducing maladaptive coping behaviors associated with EDs.

In the context of therapeutic interventions, this study's findings suggest that the significant mediating role of maladaptive CERS in the relationship between CM and EDs should inform future approaches. Interventions should prioritize targeting these maladaptive processes. Cognitive Behavioral Therapy-Enhanced (CBT-E) (Cooper & Fairburn, 2011)**,** a well-established treatment for EDs, could benefit from incorporating specific techniques aimed at reducing maladaptive strategies such as rumination, catastrophizing, and self-blame. By directly addressing these cognitive ER patterns, particularly among individuals with a history of CM, CBT-E may achieve more effective treatment outcomes. Tailoring

CBT-E protocols to include psychoeducation on the role of CERS could empower patients to break the cycle of emotional dysregulation and disordered eating.

Dialectical Behavior Therapy (DBT) is a comprehensive therapeutic approach that emphasizes emotion regulation, mindfulness, distress tolerance, and interpersonal effectiveness (Linehan, 1993). It is particularly effective for individuals who struggle with emotional dysregulation and maladaptive strategies, including those with EDs (Rozakou-Soumalia et al., 2021). Building on the findings of this study, future DBT interventions could prioritize addressing maladaptive cognitive emotion regulation strategies, such as rumination and catastrophizing, which were found to mediate the relationship between CM and EDs. By targeting these specific tendencies, DBT could enhance its efficacy in reducing disordered eating behaviors.

Although this study did not find a significant mediating role for adaptive CERS in EDs, their relevance in broader psychopathology remains noteworthy. Adaptive strategies, such as cognitive reappraisal, may still be instrumental in promoting emotional resilience, particularly for individuals with a history of emotion-related CM. Future therapeutic approaches could explore methods to enhance adaptive strategies in these populations, which may provide protective benefits against the development of other psychological disorders. Integrating adaptive CERS training into existing treatments could support long-term emotional well-being and complement efforts to mitigate maladaptive tendencies.

5.6. Conclusion and Significance

In conclusion, this study, grounded in transdiagnostic developmental perspective, provides evidence to the literature indicating that different forms of CM, except for CSA, exert significant and direct influences on the development of EDs. Notably, the research reveals that all forms of CM are significantly related to an increase in the total score of EDs through maladaptive CERS. In cases involving CSA and CEN, maladaptive CERS fully mediate the relationship between CM and EDs. Conversely, adaptive CERS does not exhibit any mediating role in the relationship between CM and EDs; however, it is evident

that emotion-related CM—namely, CEA, CEN, and parental OP-OC—is negatively associated with the utilization of adaptive CERS. This means that increases in emotional maltreatment are related with decreases in the implication of adaptive CERS. Furthermore, these types of maltreatment are found to be associated with maladaptive CERS to a greater extent compared to other forms. These findings suggest that emotional maltreatment potentially disrupts emotion regulation processes more profoundly than other forms of maltreatment.

This research contributes significantly to the understanding of the interplay between CM and EDs by elucidating the mediating roles of both adaptive and maladaptive CERS. The investigation was important for several reasons. Firstly, there exists a notable paucity of studies that have explicitly examined cognitive strategies for emotion regulation within the context of CM and EDs. The findings from this study enrich the existing literature by providing evidence that cognitive emotion regulation strategies serve as crucial mediators in the relationship between various forms of CM and EDs. Secondly, this study distinguishes itself by encompassing both adaptive and maladaptive CERS, in contrast to the predominant body of research that has primarily concentrated on the difficulties in emotion dysregulation. This approach allows for a comprehensive understanding of the significance of maladaptive CERS, which are found to be predicted by all forms of CM and related to EDs.

Notably, the research provides critical insights into the impact of all forms of CM on EDs, including the less frequently studied parental OP-OC. Collectively, these findings offer a nuanced understanding of the different forms of CM and their unique associations with the other variables. Lastly, the assessment of adaptive CERS demonstrates a new understanding that emotion-related maltreatment—namely CEN, CEA, and parental OP-OC—is adversely related to the utilization of adaptive CERS. Despite not being the main focus of this study, this finding emphasizes the complex connections between emotion-related maltreatment and the challenges in employing adaptive strategies for regulating emotions.

CHAPTER VI

CONCLUSION

This study sought to examine the complex interplay between childhood maltreatment (CM), cognitive emotion regulation strategies (CERS), and eating disorders (EDs) among the general population in Turkiye, utilizing the developmental framework proposed by McLaughlin et al. (2020). The aim of the current study was to explore the role of CERS in the association between CM experiences and ED symptomatology. From this perspective, the study investigated the relationship between various types of CM, including physical, sexual and emotional abuse, physical and emotional neglect, and the total score of EDs and the mediating role of both adaptive and maladaptive CERS in this association.

The findings provided substantial evidence for the objectives of this study. The results indicated that there are associations between the different types of CM and an increase in the total score of EDs. Notably, maladaptive CERS mediated this relationship for each type of CM. In particular, maladaptive CERS played a crucial role by fully mediating the relationship between emotional neglect (CEN) and sexual abuse (CSA). In other words, maladaptive CERS can be identified as the primary factor responsible for the association between both CSA and CEN and the total score of EDs. Conversely, adaptive CERS did not demonstrate any association with the total score of EDs; thus, it did not mediate the relationships between the types of CM and EDs. This might suggests that adaptive CERS does not serve as a protective factor against EDs. This finding underscores the significant role of maladaptive CERS, particularly in relation to CSA and EDs.

Moreover, although all types of CM were significantly associated with maladaptive CERS—particularly with comparatively stronger coefficients for emotion-related maltreatments (CEA, CEN, and parental OP-OC)—not all types demonstrated significant

associations with adaptive CERS. Instead, only emotion-related maltreatment displayed significant relationship with adaptive CERS, revealing a negative direction. These findings provide evidence for the studies that claim emotion-related maltreatment types have more profound impacts on emotion regulation processes.

The findings of this study contribute significantly to addressing gaps in the existing literature by highlighting the critical role of CERS and providing a detailed understanding of the individual impact of different types of CM on ED symptomatology. The results reveal that all forms of CM are significantly associated with higher ED scores through the mediating role of maladaptive CERS. Furthermore, a comparative analysis of various maltreatment types offers a nuanced perspective on how specific forms of CM are negatively associated with adaptive CERS, which are essential for promoting long-term mental health and well-being.

The practical implications of these findings are noteworthy. Interventions for EDs could greatly benefit from integrating trauma-informed approaches that address the various types of CM individuals may have experienced. Supporting individuals in developing healthier ways of thinking and managing their emotions, particularly by minimizing maladaptive CERS and encouraging adaptive ones, can significantly enhance therapeutic outcomes. By addressing the emotional effects of CM, such interventions may help reduce its psychological impact on eating disorder symptoms and foster more positive recovery trajectories. Such interventions might prioritize reducing the use of maladaptive emotion regulation strategies to mitigate the psychological impacts of CM on eating disorder symptoms. For policymakers and practitioners in Turkiye, these findings underline the need for comprehensive child protection programs that not only prevent maltreatment but also offer parenting education initiatives. Early intervention programs should include awareness campaigns and counseling services aimed at diminishing the long-term effects of CM, thereby promoting healthier emotional development and overall well-being.

In conclusion, this thesis enhances the understanding of the intricate mechanisms between CM, emotion regulation, and EDs. While valuable contributions are offered by the

findings, areas for future research are also highlighted, such as the evaluation of the distinct roles of each CERS in uncovering their specific contributions to ED symptomatology. Furthermore, the employment of mixed-methods designs, including symptom-level analyses and qualitative approaches, is suggested, as these could provide deeper insights into the mechanisms that connect CM, emotion regulation, and EDs. Additionally, the necessity of conducting longitudinal studies to examine causality is noted. It is anticipated that by continuing to build upon this foundation, more effective prevention and treatment strategies can be developed to support individuals who are affected by these profound challenges.

REFERENCES

Adams, V., Watson, H. J., Mazzucchelli, T., Jones, E., Callaghan, T., Bills, E., & Egan, S. J. (2024). Direct, indirect, and reciprocal associations between perfectionism, compulsive exercise and eating disorder pathology in adolescents with eating disorders. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *29*(1), 21. https://doi.org/10.1007/s40519-024-01650-y

Afifi, T. O., Sareen, J., Fortier, J., Taillieu, T., Turner, S., Cheung, K., & Henriksen, C. A. (2017). Child maltreatment and eating disorders among men and women in adulthood: Results from a nationally representative United States sample. *International Journal of Eating Disorders*, *50*(11), 1281–1296. https://doi.org/10.1002/eat.22783

Agnew-Blais, J., & Danese, A. (2016). Childhood maltreatment and unfavourable clinical outcomes in bipolar disorder: A systematic review and meta-analysis. *The Lancet Psychiatry*, *3*(4), 342–349. https://doi.org/10.1016/S2215-0366(15)00544-1

Aigner, M., Treasure, J., Kaye, W., & Kasper, S. (2011). World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Pharmacological Treatment of Eating Disorders. *The World Journal of Biological Psychiatry*, *12*(6), 400–443. https://doi.org/10.3109/15622975.2011.602720

Akgöz Aktaş, G., Alpay, E. H., & Aydın, A. (2023). Understanding the Link between Childhood Emotional Abuse and Eating Behaviors: The Mediating Role of Self-Criticism. *Journal of Aggression, Maltreatment and Trauma*, *32*(11), 1604–1621. https://doi.org/10.1080/10926771.2022.2164533

Aldao, A., Jazaieri, H., Goldin, P. R., & Gross, J. J. (2014). Adaptive and maladaptive emotion regulation strategies: Interactive effects during CBT for social anxiety disorder. *Journal of Anxiety Disorders*, *28*(4), 382–389. https://doi.org/10.1016/j.janxdis.2014.03.005

Aldao, A., & Nolen-Hoeksema, S. (2010). Specificity of cognitive emotion regulation strategies: A transdiagnostic examination. *Behaviour Research and Therapy*, *48*(10), 974–983. https://doi.org/10.1016/j.brat.2010.06.002

Aldao, A., & Nolen-Hoeksema, S. (2012). When are adaptive strategies most predictive of psychopathology? *Journal of Abnormal Psychology*, *121*(1), 276–281. https://doi.org/10.1037/a0023598

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review*, *30*(2), 217–237. https://doi.org/10.1016/j.cpr.2009.11.004

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). American Psychiatric Association.

American Psychiatric Association. (2000). *DSM-IV-TR*. American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890420249.dsm-iv-tr

American Psychiatric Association. (2006). Treatment of patients with eating disorders,third edition. American Psychiatric Association. *The American Journal of Psychiatry*, *163*(7 Suppl), 4–54.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. American Psychiatric Association.

APA. (2018). Maltreatment. In *American Psychological Association (APA)*.

Arbuthnott, A. E., Lewis, S. P., & Bailey, H. N. (2015). Rumination and Emotions in Nonsuicidal Self-Injury and Eating Disorder Behaviors: A Preliminary Test of the Emotional Cascade Model. *Journal of Clinical Psychology*, *71*(1), 62–71. https://doi.org/10.1002/jclp.22115

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality Rates in Patients With Anorexia Nervosa and Other Eating Disorders: A Meta-analysis of 36 Studies. *Archives of General Psychiatry*, *68*(7), 724–731. https://doi.org/10.1001/archgenpsychiatry.2011.74

Baile, J. I., & Rabito-Alcón, M. F. (2022). Cognitive Behavioural Therapy for an Adolescent with Anorexia Nervosa. *Children*, *9*(1), 92. https://doi.org/10.3390/children9010092

Baker, J. H., Maes, H. H., Lissner, L., Aggen, S. H., Lichtenstein, P., & Kendler, K. S. (2009). Genetic risk factors for disordered eating in adolescent males and females. *Journal of Abnormal Psychology*, *118*(3), 576–586. https://doi.org/10.1037/a0016314

Balzarotti, S., Biassoni, • F, Villani, • D, Prunas, • A, & Velotti, • P. (2016). Individual Differences in Cognitive Emotion Regulation: Implications for Subjective and Psychological Well-Being. *Journal of Happiness Studies*, *17*, 125–143. https://doi.org/10.1007/s10902-014-9587-3

Ban, J., & Oh, I. (2016). Mediating effects of teacher and peer relationships between parental abuse/neglect and emotional/behavioral problems. *Child Abuse and Neglect*, *61*, 35–42. https://doi.org/10.1016/j.chiabu.2016.09.010

Barakat, S., McLean, S. A., Bryant, E., Le, A., Marks, P., Aouad, P., Barakat, S., Boakes, R., Brennan, L., Bryant, E., Byrne, S., Caldwell, B., Calvert, S., Carroll, B., Castle, D., Caterson, I., Chelius, B., Chiem, L., Clarke, S., … Touyz, S. (2023). Risk factors for eating disorders: findings from a rapid review. In *Journal of Eating Disorders* (Vol. 11, Issue 1). BioMed Central Ltd. https://doi.org/10.1186/s40337-022-00717-4

Barch, D. M. (2020). What Does It Mean to Be Transdiagnostic and How Would We Know? In *American Journal of Psychiatry* (Vol. 177, Issue 5, pp. 370–372). American Psychiatric Association. https://doi.org/10.1176/appi.ajp.2020.20030243

Bazo Perez, M., Hayes, T. B., & Frazier, L. D. (2023). Beyond generalized anxiety: the association of anxiety sensitivity with disordered eating. *Journal of Eating Disorders*, *11*(1), 173. https://doi.org/10.1186/s40337-023-00890-0

Becker, D. F., & Grilo, C. M. (2011). Childhood maltreatment in women with binge-eating disorder: Associations with psychiatric comorbidity, psychological functioning, and eating pathology. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *16*(2), e113–e120. https://doi.org/10.1007/BF03325316

Behr Gomes Jardim, G., Novelo, M., Spanemberg, L., von Gunten, A., Engroff, P., Nogueira, E. L., & Cataldo Neto, A. (2018). Influence of childhood abuse and neglect subtypes on late-life suicide risk beyond depression. *Child Abuse and Neglect*, *80*, 249–256. https://doi.org/10.1016/j.chiabu.2018.03.029

Bello, N. T., Leyton, C. E., Kakoschke, N., Fostinelli, S., De Amicis, R., Leone, A., Giustizieri, V., Binetti, G., Bertoli, S., Battezzati, A., & Cappa, S. F. (2020). *Eating Behavior in Aging and Dementia: The Need for a Comprehensive Assessment*. *7*, 604488. https://doi.org/10.3389/fnut.2020.604488

Berkman, N., Brownley, K., Peat, C., Lohr, K., Cullen, K., Morgan, L., Bann, C., Wallace, I., & Bulik, C. (2015). *Management and Outcomes of Binge-Eating Disorder Comparative Effectiveness Review Number 160*. www.effectivehealthcare.ahrq.gov.

Bernstein, D. P., Fink, L., Handeisman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareto, E., & Ruggiero, J. (1994). *Initial Reliability and Validity of a New Retrospective Measure of Child Abuse and Neglect*.

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stokes, J., Handelsman, L., Medrano, M., Desmond, D., & Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse and Neglect*, *27*(2), 169–190. https://doi.org/10.1016/S0145-2134(02)00541-0

Bondurant, B. (2001). University Women's Acknowledgment of Rape. *Violence Against Women*, *7*(3), 294–314. https://doi.org/10.1177/1077801201007003004

Bordo, S. (1993). *Unbearable weight: Feminism, Western culture, and the body*. University of California Press.

Borg, S. L., Schaefer, L. M., Hazzard, V. M., Herting, N., Peterson, C. B., Crosby, R. D., Crow, S. J., Engel, S. G., & Wonderlich, S. A. (2022). Relationships Between Childhood Abuse and Eating Pathology Among Individuals with Binge-Eating Disorder: examining the Moderating Roles of Self-Discrepancy and Self-Directed Style. *Eating Disorders*, *30*(4), 355–369. https://doi.org/10.1080/10640266.2020.1864588

Bould, H., Sovio, U., Koupil, I., Dalman, C., Micali, N., Lewis, G., & Magnusson, C. (2015). Do eating disorders in parents predict eating disorders in children? Evidence from a Swedish cohort. *Acta Psychiatrica Scandinavica*, *132*(1), 51–59. https://doi.org/10.1111/acps.12389

Branley, D. B., & Covey, J. (2017). Pro-ana versus pro-recovery: A content analytic comparison of social media users' communication about eating disorders on Twitter and Tumblr. *Frontiers in Psychology*, *8*(AUG). https://doi.org/10.3389/fpsyg.2017.01356

Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: Focus on PTSD. In *Eating Disorders* (Vol. 15, Issue 4, pp. 285–304). https://doi.org/10.1080/10640260701454311

Brockmeyer, T., Holtforth, M. G., Bents, H., Kämmerer, A., Herzog, W., & Friederich, H.-C. (2012). Starvation and emotion regulation in anorexia nervosa. *Comprehensive Psychiatry*, *53*(5), 496–501. https://doi.org/10.1016/j.comppsych.2011.09.003

Brockmeyer, T., Skunde, M., Wu, M., Bresslein, E., Rudofsky, G., Herzog, W., & Friederich, H. C. (2014). Difficulties in emotion regulation across the spectrum of eating disorders. *Comprehensive Psychiatry*, *55*(3), 565–571. https://doi.org/10.1016/j.comppsych.2013.12.001

Brown, C., & Mehler, P. S. (2015). Medical complications of anorexia nervosa and their treatments: an update on some critical aspects. In *Eating and Weight Disorders* (Vol. 20, Issue 4, pp. 419–425). Springer International Publishing. https://doi.org/10.1007/s40519-015-0202-3

Brown, T. A., Avery, J. C., Jones, M. D., Anderson, L. K., Wierenga, C. E., & Kaye, W. H. (2018). The Impact of Alexithymia on Emotion Dysregulation in Anorexia Nervosa and Bulimia Nervosa over Time. *European Eating Disorders Review*, *26*(2), 150–155. https://doi.org/10.1002/erv.2574

Brustenghi, F., Mezzetti, F. A. F., Di Sarno, C., Giulietti, C., Moretti, P., & Tortorella, A. (2019). Eating Disorders: the Role of Childhood Trauma and the Emotion Dysregulation. *Psychiatria Danubina*, *31*(Suppl 3), 509–511.

Bud, S., Nechita, D., & Szentagotai Tatar, A. (2023). Emotion regulation strategies in borderline personality disorder: a meta-analysis. *Clinical Psychologist*, *27*(2), 142–159. https://doi.org/10.1080/13284207.2022.2152668

Burns, E. E., Fischer, S., Jackson, J. L., & Harding, H. G. (2012). Deficits in emotion regulation mediate the relationship between childhood abuse and later eating disorder symptoms. *Child Abuse and Neglect*, *36*(1), 32–39. https://doi.org/10.1016/j.chiabu.2011.08.005

Caceres, B. A., Britton, L. E., Cortes, Y. I., Makarem, N., & Suglia, S. F. (2022). Investigating the associations between childhood trauma and cardiovascular health in midlife. *Journal of Traumatic Stress*, *35*(2), 409–423. https://doi.org/10.1002/jts.22752

Cailhol, L., Pelletier, É., Rochette, L., Laporte, L., David, P., Villeneuve, É., Paris, J., & Lesage, A. (2017). Prevalence, Mortality, and Health Care Use among Patients with Cluster B Personality Disorders Clinically Diagnosed in Quebec: A Provincial Cohort Study, 2001-2012. *Canadian Journal of Psychiatry*, *62*(5), 336–342. https://doi.org/10.1177/0706743717700818

Call, C., Walsh, B. T., & Attia, E. (2013). From DSM-IV to DSM-5: Changes to eating disorder diagnoses. In *Current Opinion in Psychiatry* (Vol. 26, Issue 6, pp. 532–536). https://doi.org/10.1097/YCO.0b013e328365a321

Carano, A., De Berardis, D., Gambi, F., Di Paolo, C., Campanella, D., Pelusi, L., Sepede, G., Mancini, E., La Rovere, R., Salini, G., Cotellessa, C., Salerno, R. M., & Ferro, F. M. (2006). Alexithymia and body image in adult outpatients with binge eating disorder. *International Journal of Eating Disorders*, *39*(4), 332–340. https://doi.org/10.1002/eat.20238

Carbone, G. A., Imperatori, C., Adenzato, M., Presti, A. Lo, Farina, B., & Ardito, R. B. (2024). Is parental overcontrol a specific form of child maltreatment? Insights from a resting state EEG connectivity study. *Child Abuse and Neglect*, *155*. https://doi.org/10.1016/j.chiabu.2024.106962

Carver, C. S., Scheier, M. F., & Weintraub, K. J. (1989). Assessing Coping Strategies: A Theoretically Based Approach. *Journal of Personality and Social Psychology*, *56*(2), 267–283. https://doi.org/10.1037/0022-3514.56.2.267

Casey, B. J., Trainor, R. J., Orendi, J. L., Schubert, A. B., Nystrom, L. E., Giedd, J. N., Castellanos, F. X., Haxby, J. V, Noll, D. C., Cohen, J. D., Forman, S. D., Dahl, R. E., & Rapoport, J. L. (1997). A Developmental Functional MRI Study of Prefrontal Activation during Performance of a Go-No-Go Task. *Journal of Cognitive Neuroscience*, *9*(6), 835–847.

Caslini, M., Bartoli, F., Crocamo, C., Dakanalis, A., Clerici, M., & Carrà, G. (2016). Disentangling the association between child abuse and eating disorders: A systematic

review and meta-analysis. In *Psychosomatic Medicine* (Vol. 78, Issue 1, pp. 79–90). Lippincott Williams and Wilkins. https://doi.org/10.1097/PSY.0000000000000233

Cassiers, L. L. M., Sabbe, B. G. C., Schmaal, L., Veltman, D. J., Penninx, B. W. J. H., & Eede, F. Van Den. (2018). Structural and functional brain abnormalities associated with exposure to different childhood trauma subtypes: A systematic review of neuroimaging findings. *Frontiers in Psychiatry*, *9*(AUG). https://doi.org/10.3389/fpsyt.2018.00329

Cassioli, E., Rossi, E., D'Anna, G., Martelli, M., Hazzard, V. M., Crosby, R. D., Wonderlich, S. A., Ricca, V., & Castellini, G. (2022). A 1-year follow-up study of the longitudinal interplay between emotion dysregulation and childhood trauma in the treatment of anorexia nervosa. International Journal of Eating Disorders, 55(1), 98–107. https://doi.org/10.1002/eat.23647

Castellini, G., Lelli, L., Cassioli, E., Ciampi, E., Zamponi, F., Campone, B., Monteleone, A. M., & Ricca, V. (2018). Different outcomes, psychopathological features, and comorbidities in patients with eating disorders reporting childhood abuse: A 3-year follow-up study. *European Eating Disorders Review*, *26*(3), 217–229. https://doi.org/10.1002/erv.2586

Cay, M., Gonzalez-Heydrich, J., Teicher, M. H., van der Heijden, H., Ongur, D., Shinn, A. K., & Upadhyay, J. (2022). Childhood maltreatment and its role in the development of pain and psychopathology. *The Lancet Child & Adolescent Health*, *6*(3), 195–206. https://doi.org/10.1016/S2352-4642(21)00339-4

CDC. (2024, March 19). *Adult BMI Categories*. Https://Www.Cdc.Gov/Bmi/Adult-Calculator/Bmi-Categories.Html.

Centers for Disease Control and Prevention (CDC). (2023, June 29). *Fast Facts: Preventing Adverse Childhood Experiences*.

Chen, E., Turiano, N. A., Mroczek, D. K., & Miller, G. E. (2016). Association of reports of childhood abuse and all-cause mortality rates in women. *JAMA Psychiatry*, *73*(9), 920–927. https://doi.org/10.1001/jamapsychiatry.2016.1786

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., Elamin, M. B., Seime, R. J., Shinozaki, G., Prokop, L. J., & Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings*, *85*(7), 618–629. https://doi.org/10.4065/mcp.2009.0583

Christie, A. J., & Matthews, K. A. (2019). Childhood poly-victimization is associated with elevated body mass index and blunted cortisol stress response in college women. *Annals of Behavioral Medicine*, *53*(6), 563–572. https://doi.org/10.1093/abm/kay066

Cicchetti, D., & Rogosch, F. A. (1996). Equifinality and multifinality in developmental psychopathology. In *Development and Psychopathology* (Vol. 8, Issue 4, pp. 597–600). https://doi.org/10.1017/S0954579400007318

Clark, D. B., Thatcher, D. L., & Martin, C. S. (2010). Child abuse and other traumatic experiences, alcohol use disorders, and health problems in adolescence and young adulthood. *Journal of Pediatric Psychology*, *35*(5), 499–510. https://doi.org/10.1093/jpepsy/jsp117

Compas, B. E., Jaser, S. S., Bettis, A. H., Watson, K. H., Gruhn, M. A., Dunbar, J. P., Williams, E., & Thigpen, J. C. (2017). Coping, emotion regulation, and psychopathology in childhood and adolescence: A meta-analysis and narrative review. *Psychological Bulletin*, *143*(9), 939–991. https://doi.org/10.1037/bul0000110

Cooper, T. J. (2017). Eating disorders: Are they age-restricted? *Current Psychiatry*, *16*(7), 54–55.

Cooper, Z., & Fairburn, C. G. (2011). The Evolution of "Enhanced" Cognitive Behavior Therapy for Eating Disorders: Learning From Treatment Nonresponse. *Cognitive and Behavioral Practice*, *18*(3), 394–402. https://doi.org/10.1016/j.cbpra.2010.07.007

Corstorphine, E. (2006). Cognitive–Emotional–Behavioural Therapy for the eating disorders: working with beliefs about emotions. *European Eating Disorders Review*, *14*(6), 448–461. https://doi.org/10.1002/erv.747

Craba, A., Mazza, M., Marano, G., Crosta, M. L., Moroni, F., Di Pietro, S., Balocchi, M., Della Casa, S., Rinaldi, L., Janiri, L., & Sani, G. (2023). Defense Mechanisms and Parenting Styles in Patients With Anorexia and Bulimia. *Journal of Nervous & Mental Disease*, *211*(3), 174–181. https://doi.org/10.1097/NMD.0000000000001597

Creswell, J. W. (2015). *Educational research: planning, conducting, and evaluating quantitative and qualitative research* (4th ed.). Pearson.

Culbert, K. M., Racine, S. E., & Klump, K. L. (2015). Research Review: What we have learned about the causes of eating disorders - A synthesis of sociocultural, psychological, and biological research. In *Journal of Child Psychology and Psychiatry and Allied Disciplines* (Vol. 56, Issue 11, pp. 1141–1164). https://doi.org/10.1111/jcpp.12441

Dalle Grave, R., Calugi, S., Doll, H. A., & Fairburn, C. G. (2013). Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: An alternative to family therapy? *Behaviour Research and Therapy*, *51*(1), R9–R12. https://doi.org/10.1016/j.brat.2012.09.008

Dalle Grave, R., Sartirana, M., & Calugi, S. (2021). Complex cases and comorbidity in eating disorders: Assessment and management. In *Complex Cases and Comorbidity in Eating Disorders: Assessment and Management*. Springer International Publishing. https://doi.org/10.1007/978-3-030-69341-1

Dawson, D., Strodl, E., & Kitamura, H. (2022). Childhood maltreatment and disordered eating: The mediating role of emotion regulation. *Appetite*, *172*. https://doi.org/10.1016/j.appet.2022.105952

Degortes, D., Santonastaso, P., Zanetti, T., Tenconi, E., Veronese, A., & Favaro, A. (2014). Stressful Life Events and Binge Eating Disorder. *European Eating Disorders Review*, *22*(5), 378–382. https://doi.org/10.1002/erv.2308

Dey, M., & Mohler-Kuo, M. (2013). An analysis of non-response in a Swiss national survey. *International Journal of Public Health*, *58*(2), 323–326. https://doi.org/10.1007/s00038-012-0377-6

Dong, S., Dong, Q., Chen, H., & Yang, S. (2023). Childhood emotional neglect and adolescent depression: the role of self-compassion and friendship quality. *Current Psychology*, *42*(28), 24451–24463. https://doi.org/10.1007/s12144-022-03539-4

Dreher, D., Feldman, D., & Numan, R. (2014). CONTROLLING PARENTS SURVEY: Measuring the Influence of Parental Control on Personal Development in College Students. *College Student Affairs Journal*, *32*(1), 97–111.

Duncanson, E., Chur-Hansen, A., & Jesudason, S. (2022). Patient perspectives of coping with automated peritoneal dialysis. *Peritoneal Dialysis International: Journal of the International Society for Peritoneal Dialysis*, *42*(4), 344–352. https://doi.org/10.1177/08968608211043411

Duru, E., & Balkıs, M. (2024). COVID-19 Related Negative Life Events and Psychological Distress: The Role of Emotion and Cognitive Emotion Regulation Strategies. *Journal of Rational - Emotive and Cognitive - Behavior Therapy*, *42*(1), 69–91. https://doi.org/10.1007/s10942-022-00488-6

Dworschak, C., Polack, R. G., Winschel, J., Joormann, J., & Kober, H. (2023). Emotion regulation and disordered eating behaviour in youths: Two daily-diary studies. *European Eating Disorders Review*, *31*(5), 655–669. https://doi.org/10.1002/erv.2993

Elfil, M., & Negida, A. (2016). NN(I): pp-pp EDUCATIONAL Cite this article as: Elfil M, Negida A. Sampling methods in Clinical Research; an Educational Review. *Emergency. YYYY; NN (I)*, pp-pp. https://doi.org/10.22037/emergency.v5i1.15215

Emery, R. L., Yoon, C., Mason, S. M., & Neumark-Sztainer, D. (2021). Childhood maltreatment and disordered eating attitudes and behaviors in adult men and

women:Findings from project EAT. *Appetite*, *163*. https://doi.org/10.1016/j.appet.2021.105224

Erford, B. T., Richards, T., Peacock, E., Voith, K., McGair, H., Muller, B., Duncan, K., & Chang, C. Y. (2013). Counseling and Guided Self-Help Outcomes for Clients With Bulimia Nervosa: A Meta-Analysis of Clinical Trials From 1980 to 2010. *Journal of Counseling & Development*, *91*(2), 152–172. https://doi.org/10.1002/j.1556-6676.2013.00083.x

Ernst, M., Tibubos, A. N., Werner, A., Beutel, M. E., Plener, P. L., Fegert, J. M., & Brähler, E. (2019). Sex-dependent associations of childhood neglect and bodyweight across the life span. *Scientific Reports*, *9*(1). https://doi.org/10.1038/s41598-019-41367-y

Esin, K., & Ayyıldız, F. (2022). Validity and reliability of the Turkish version of the Eating Disorder Examination Questionnaire (EDE-Q-13): short-form of EDE-Q. *Journal of Eating Disorders*, *10*(1). https://doi.org/10.1186/s40337-022-00628-4

Fairburn, C. G., & Beglin, S. J. (1994). *Assessment of Eating Disorders: Interview or Self-Report Questionnaire?*

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Palmer, R. L., & Dalle Grave, R. (2013). Enhanced cognitive behaviour therapy for adults with anorexia nervosa: A UK–Italy study. *Behaviour Research and Therapy*, *51*(1), R2–R8. https://doi.org/10.1016/j.brat.2012.09.010

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. In *Behaviour Research and Therapy* (Vol. 41, Issue 5, pp. 509–528). Elsevier Ltd. https://doi.org/10.1016/S0005-7967(02)00088-8

Fairburn, C., & Harrison, P. (2003). *Eating Disorders*. https://doi.org/10.1016/S0140-6736(03)12378-1

Farina, B., & Imperatori, C. (2024). Are Traumatic Disintegration, Detachment, and Dissociation Separate Pathogenic Processes Related to Attachment Trauma? A Working Hypothesis for Clinicians and Researchers. *Psychopathology*, *57*(3), 236–247. https://doi.org/10.1159/000535191

Farstad, S. M., McGeown, L. M., & von Ranson, K. M. (2016). Eating disorders and personality, 2004–2016: A systematic review and meta-analysis. *Clinical Psychology Review*, *46*, 91–105. https://doi.org/10.1016/j.cpr.2016.04.005

Favaro, A., Busetto, P., Collantoni, E., & Santonastaso, P. (2019). The Age of Onset of Eating Disorders. In *Age of Onset of Mental Disorders* (pp. 203–216). Springer International Publishing. https://doi.org/10.1007/978-3-319-72619-9_11

Festinger, L. (1954). A Theory of Social Comparison Processes. *Human Relations*, *7*(2), 117–140. https://doi.org/10.1177/001872675400700202

Fortier, J., Stewart-Tufescu, A., Salmon, S., Garces Davila, I., MacMillan, H. L., Gonzalez, A., Mathews, B., Struck, S., Taillieu, T., & Afifi, T. O. (2020). What type of survey research questions are identified by adults as upsetting? A focus on child maltreatment. *Child Abuse & Neglect*, *109*, 104764. https://doi.org/10.1016/j.chiabu.2020.104764

Freidl, E. K., Hoek, H. W., & Attia, E. (2012). Anorexia Nervosa in DSM-5. *Psychiatric Annals*, *42*(11), 414–417. https://doi.org/10.3928/00485713-20121105-07

Friedman, J. K., Yoon, C. Y., Emery Tavernier, R. L., Mason, S. M., & Neumark-Sztainer, D. (2023). Associations of childhood maltreatment with binge eating and binge drinking in emerging adult women. *Preventive Medicine Reports*, *33*. https://doi.org/10.1016/j.pmedr.2023.102217

Furnham, A., & Adam-Saib, S. (2001). Abnormal eating attitudes and behaviours and perceived parental control: a study of white British and British-Asian school girls. *Social Psychiatry and Psychiatric Epidemiology*, *36*(9), 462–470. https://doi.org/10.1007/s001270170025

Gadalla, T., & Piran, N. (2007). Co-occurrence of eating disorders and alcohol use disorders in women: a meta analysis. *Arch Womens Ment Health*, *10*, 133–140. https://doi.org/10.1007/s00737-007-0184-x

Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000-2018 period: A systematic literature review. In *American Journal of Clinical Nutrition* (Vol. 109, Issue 5, pp. 1402–1413). Oxford University Press. https://doi.org/10.1093/ajcn/nqy342

Garnefski, N., & Kraaij, V. (2006). Relationships between cognitive emotion regulation strategies and depressive symptoms: A comparative study of five specific samples. *Personality and Individual Differences*, *40*(8), 1659–1669. https://doi.org/10.1016/j.paid.2005.12.009

Garnefski, N., & Kraaij, V. (2007). The cognitive emotion regulation questionnaire: Psychometric features and prospective relationships with depression and anxiety in adults. *European Journal of Psychological Assessment*, *23*(3), 141–149. https://doi.org/10.1027/1015-5759.23.3.141

Garnefski, N., Kraaij, V., & Spinhoven, P. (n.d.). *Negative life events, cognitive emotion regulation and emotional problems*. www.elsevier.com/locate/paid

Garnefski, N., Kraaij, V., & Spinhoven, P. (2001). *Negative life events, cognitive emotion regulation and emotional problems*. www.elsevier.com/locate/paid

Ghanei, N., Pourshahriar, H., & Shokri, O. (2020). The relationship between childhood emotional maltreatment and disordered eating behaviors among students: Mediating role of emotion dysregulation: A cross-sectional study. *Chron Dis J*, *8*(3), 139–151. https://doi.org/10.22122/cdj.v8i3.520

Giel, K. E., Bulik, C. M., Fernandez-Aranda, F., Hay, P., Keski-Rahkonen, A., Schag, K., Schmidt, U., & Zipfel, S. (2022). Binge eating disorder. *Nature Reviews Disease Primers*, *8*(1), 16. https://doi.org/10.1038/s41572-022-00344-y

Gioia, F., Boursier, V., Franceschini, C., & Musetti, A. (2022). The Effects of Childhood Emotional and Physical Maltreatment on Adolescents' Disordered Eating Behaviors. *Journal of Nervous & Mental Disease*, *210*(11), 831–837. https://doi.org/10.1097/NMD.0000000000001556

Godart, N., Radon, L., Curt, F., Duclos, J., Perdereau, F., Lang, F., Venisse, J. L., Halfon, O., Bizouard, P., Loas, G., Corcos, M., Jeammet, P., & Flament, M. F. (2015). Mood disorders in eating disorder patients: Prevalence and chronology of ONSET. *Journal of Affective Disorders*, *185*, 115–122. https://doi.org/10.1016/j.jad.2015.06.039

Goodwin, R. D., & Wamboldt, F. S. (2012). Childhood physical abuse and respiratory disease in the community: The role of mental health and cigarette smoking. *Nicotine and Tobacco Research*, *14*(1), 91–97. https://doi.org/10.1093/ntr/ntr126

Gorrell, S., Hail, L., & Reilly, E. E. (2023). Predictors of Treatment Outcome in Eating Disorders: A Roadmap to Inform Future Research Efforts. *Current Psychiatry Reports*, *25*, 213–222. https://doi.org/10.1007/s11920-023-01416-w

Grilo, C. M., Henderson, K. E., Bell, R. L., & Crosby, R. D. (2013). Eating disorder examination-questionnaire factor structure and construct validity in bariatric surgery candidates. *Obesity Surgery*, *23*(5), 657–662. https://doi.org/10.1007/s11695-012-0840-8

Grilo, C. M., & Masheb, R. M. (2001). *Childhood Psychological, Physical, and Sexual Maltreatment in Outpatients with Binge Eating Disorder: Frequency and Associations with Gender, Obesity, and Eating-Related Psychopathology*.

Grilo, C. M., & Udo, T. (2021). Examining the significance of age of onset in persons with lifetime anorexia nervosa: Comparing child, adolescent, and emerging adult onsets in nationally representative U.S. study. *International Journal of Eating Disorders*, *54*(9), 1632–1640. https://doi.org/10.1002/eat.23580

Grogan, S. (2017). *Body Image: Understanding Body Dissatisfaction in Men, Women and Children* (3rd ed.). Routledge.

Gross, J. J. (1999). Emotion regulation: Past, present, future. *Cognition and Emotion*, *13*(5), 551–573. https://doi.org/10.1080/026999399379186

Gross, J. J. (2015). Emotion Regulation: Current Status and Future Prospects. *Psychological Inquiry*, *26*(1), 1–26. https://doi.org/10.1080/1047840X.2014.940781

Gruber, M., König, D., Holzhäuser, J., Castillo, D. M., Blüml, V., Jahn, R., Leser, C., Werneck-Rohrer, S., & Werneck, H. (2020). Parental feeding practices and the relationship with parents in female adolescents and young adults with eating disorders: A case control study. *PLoS ONE*, *15*(11 November). https://doi.org/10.1371/journal.pone.0242518

Gruhn, M. A., & Compas, B. E. (2020). Effects of maltreatment on coping and emotion regulation in childhood and adolescence: A meta-analytic review. *Child Abuse & Neglect*, *103*, 104446. https://doi.org/10.1016/j.chiabu.2020.104446

Hambleton, A. L., Hanstock, T. L., Simeone, R., & Sperling, M. (2020). Group-Delivered Enhanced Cognitive Behavior Therapy: A Focus on a Young Adult Woman With Bulimia Nervosa. *Clinical Case Studies*, *19*(1), 62–77. https://doi.org/10.1177/1534650119886653

Hambleton, A., Pepin, G., Le, A., Maloney, D., Aouad, P., Barakat, S., Boakes, R., Brennan, L., Bryant, E., Byrne, S., Caldwell, B., Calvert, S., Carroll, B., Castle, D., Caterson, I., Chelius, B., Chiem, L., Clarke, S., Conti, J., … Maguire, S. (2022). Psychiatric and medical comorbidities of eating disorders: findings from a rapid review of the literature. *Journal of Eating Disorders*, *10*(1), 132. https://doi.org/10.1186/s40337-022-00654-2

Hamid, M., Qureshi, A., Waheed, A., & Hashmi, Q.-A. (2023). Sociocultural Influence and Eating Problem in University Students: Mediating Role of Body Image Dissatisfaction. *Pakistan Journal of Psychological Research*, *38*(4), 689–707. https://doi.org/10.33824/PJPR.2023.38.4.40

Hampshire, C., Mahoney, B., & Davis, S. K. (2022). Parenting Styles and Disordered Eating Among Youths: A Rapid Scoping Review. In *Frontiers in Psychology* (Vol. 12). Frontiers Media S.A. https://doi.org/10.3389/fpsyg.2021.802567

Harrison, A., Sullivan, S., Tchanturia, K., & Treasure, J. (2009). Emotion recognition and regulation in anorexia nervosa. Clinical Psychology & Psychotherapy, 16(4), 348–356. https://doi.org/10.1002/cpp.628

Harrison, A., Sullivan, S., Tchanturia, K., & Treasure, J. (2010). Emotional functioning in eating disorders: attentional bias, emotion recognition and emotion regulation. *Psychological Medicine*, *40*(11), 1887–1897. https://doi.org/10.1017/S0033291710000036

Hayes, A. F. (2022). *Introduction to Mediation, Moderation, and Conditional Process Analysis: A Regression Based Aproach* (3rd ed.). The Guilford Press.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and Commitment Therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, *44*(1), 1–25. https://doi.org/10.1016/j.brat.2005.06.006

Haynos, A. F., & Fruzzetti, A. E. (2011). Anorexia nervosa as a disorder of emotion dysregulation: Evidence and treatment implications. *Clinical Psychology: Science and Practice*, *18*(3), 183–202. https://doi.org/10.1111/j.1468-2850.2011.01250.x

Haynos, A. F., Wang, S. B., & Fruzzetti, A. E. (2018). Restrictive eating is associated with emotion regulation difficulties in a non-clinical sample. *Eating Disorders*, *26*(1), 5–12. https://doi.org/10.1080/10640266.2018.1418264

Hebebrand, J., Gradl-Dietsch, G., Peters, T., Correll, C. U., & Haas, V. (2024). The diagnosis and treatment of anorexia nervosa in childhood and adolescence. *Deutsches Ärzteblatt International*. https://doi.org/10.3238/arztebl.m2023.0248

Heleniak, C., Jenness, J. L., Vander Stoep, A., McCauley, E., & McLaughlin, K. A. (2016). Childhood Maltreatment Exposure and Disruptions in Emotion Regulation: A Transdiagnostic Pathway to Adolescent Internalizing and Externalizing Psychopathology. *Cognitive Therapy and Research*, *40*(3), 394–415. https://doi.org/10.1007/s10608-015-9735-z

Hicks White, A. A., Pratt, K. J., & Cottrill, C. (2018). The relationship between trauma and weight status among adolescents in eating disorder treatment. *Appetite*, *129*, 62–69. https://doi.org/10.1016/j.appet.2018.06.034

Hilbert, A. (2023). Psychological and medical treatments for binge-eating disorder: A research update. *Physiology and Behavior*, *269*. https://doi.org/10.1016/j.physbeh.2023.114267

Himmerich, H., Hotopf, M., Shetty, H., Schmidt, U., Treasure, J., Hayes, R. D., Stewart, R., & Chang, C. K. (2019). Psychiatric comorbidity as a risk factor for mortality in people with anorexia nervosa. *European Archives of Psychiatry and Clinical Neuroscience*, *269*(3), 351–359. https://doi.org/10.1007/s00406-018-0937-8

Himmerich, H., Kan, C., Au, K., & Treasure, J. (2021). Pharmacological treatment of eating disorders, comorbid mental health problems, malnutrition and physical health consequences. *Pharmacology & Therapeutics*, *217*, 107667. https://doi.org/10.1016/j.pharmthera.2020.107667

Ho, C. S., Jin, A., Nyunt, M. S. Z., Feng, L., & Ng, T. P. (2016). Mortality rates in major and subthreshold depression: 10-year follow-up of a Singaporean population cohort of older adults. *Postgraduate Medicine*, *128*(7), 642–647. https://doi.org/10.1080/00325481.2016.1221319

Hoerger, M. (2010). Participant Dropout as a Function of Survey Length in Internet-Mediated University Studies: Implications for Study Design and Voluntary Participation in Psychological Research. *Cyberpsychology, Behavior, and Social Networking*, *13*(6), 697–700. https://doi.org/10.1089/cyber.2009.0445

Hulbert-Williams, N. J., & Hulbert-Williams, L. (2022). Acceptance and Commitment Therapy. In H. M. Chochinov & W. Breitbart (Eds.), *Handbook of Psychiatry in Palliative Medicine 3rd edition* (pp. 582-C39.P78). Oxford University Press. https://doi.org/10.1093/med/9780197583838.003.0039

Insana, S. P., Banihashemi, L., Herringa, R. J., Kolko, D. J., & Germain, A. (2016). Childhood maltreatment is associated with altered frontolimbic neurobiological activity during wakefulness in adulthood. *Development and Psychopathology*, *28*(2), 551–564. https://doi.org/10.1017/S0954579415000589

Iqbal, F., Naqvi, G., Saleem, S., & Zahra, S. T. (2023). Mothers' overprotection and eating problems in college students: a mediatıng role of emotion dysregulation. *Journal of Postgraduate Medical Institute*, *37*(1), 46–52. https://doi.org/10.54079/jpmi.37.1.3119

Jaffee, S. R. (2017). Child Maltreatment and Risk for Psychopathology in Childhood and Adulthood. *Annual Review of Clinical Psychology*, *13*(1), 525–551. https://doi.org/10.1146/annurev-clinpsy-032816-045005

Jáuregui Lobera, I., Bolaños Ríos, P., & Garrido Casals, O. (2011). Parenting styles and eating disorders. *Journal of Psychiatric and Mental Health Nursing*, *18*(8), 728–735. https://doi.org/10.1111/j.1365-2850.2011.01723.x

Jenkins, P. E., & Davey, E. (2020). The brief (seven-item) eating disorder examination-questionnaire: Evaluation of a non-nested version in men and women. *International Journal of Eating Disorders*, *53*(11), 1809–1817. https://doi.org/10.1002/eat.23360

Jermann, F., Van Der Linden, M., D'Acremont, M., & Zermatten, A. (2006). Cognitive Emotion Regulation Questionnaire (CERQ): Confirmatory factor analysis and psychometric properties of the French translation. *European Journal of Psychological Assessment*, *22*(2), 126–131. https://doi.org/10.1027/1015-5759.22.2.126

Johnson, R. (2018). *Parenting Practices and Disordered Eating Behaviors in Adolescents*. https://scholarsarchive.byu.edu/studentpub

Joormann, J., & Stanton, C. H. (2016). Examining emotion regulation in depression: A review and future directions. In *Behaviour Research and Therapy* (Vol. 86, pp. 35–49). Elsevier Ltd. https://doi.org/10.1016/j.brat.2016.07.007

Kaye, W. H., & Bulik, C. M. (2021). Treatment of Patients With Anorexia Nervosa in the US—A Crisis in Care. *JAMA Psychiatry*, *78*(6), 591. https://doi.org/10.1001/jamapsychiatry.2020.4796

Kerig, P. K., & Alexander, A. R. (2024). Models of psychopathology. In *Encyclopedia of Adolescence* (pp. 321–333). Elsevier. https://doi.org/10.1016/B978-0-323-96023-6.00040-3

Kesmodel, U. S. (2018). Cross-sectional studies-what are they good for? *Nordic Federation of Societies of Obstetrics and Gynecology*, *97*, 388–393. https://doi.org/10.1111/aogs.13331

Kessler, H., Schwarze, M., Filipic, S., Traue, H. C., & von Wietersheim, J. (2006). Alexithymia and facial emotion recognition in patients with eating disorders. *International Journal of Eating Disorders*, *39*(3), 245–251. https://doi.org/10.1002/eat.20228

Khalil, R. B., Sleilaty, G., Richa, S., Seneque, M., Iceta, S., Rodgers, R., Alacreu-Crespo, A., Maimoun, L., Lefebvre, P., Renard, E., Courtet, P., & Guillaume, S. (2020). The impact of retrospective childhood maltreatment on eating disorders as mediated by food addiction: A cross-sectional study. *Nutrients*, *12*(10), 1–13. https://doi.org/10.3390/nu12102969

Kilpela, L. S., Marshall, V. B., Hooper, S. C., Becker, C. B., Keel, P. K., LaCroix, A. Z., Musi, N., & Espinoza, S. E. (2023). Binge eating age of onset, frequency, and associated emotional distress among women aged 60 years and over. *Eating Disorders*, *31*(5), 479–486. https://doi.org/10.1080/10640266.2023.2192600

Kimber, M., Gonzalez, A., & MacMillan, H. L. (2020). Recognizing and Responding to Child Maltreatment: Strategies to Apply When Delivering Family-Based Treatment for Eating Disorders. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.00678

Kimber, M., McTavish, J. R., Couturier, J., Boven, A., Gill, S., Dimitropoulos, G., & MacMillan, H. L. (2017). Consequences of child emotional abuse, emotional neglect and exposure to intimate partner violence for eating disorders: a systematic critical review. *BMC Psychology*, *5*(1), 33. https://doi.org/10.1186/s40359-017-0202-3

Kimhy, D., Gill, K. E., Brucato, G., Vakhrusheva, J., Arndt, L., Gross, J. J., & Girgis, R. R. (2016). The impact of emotion awareness and regulation on social functioning in individuals at clinical high risk for psychosis. *Psychological Medicine*, *46*(14), 2907–2918. https://doi.org/10.1017/S0033291716000490

Kim-Spoon, J., Cicchetti, D., & Rogosch, F. A. (2013). A Longitudinal Study of Emotion Regulation, Emotion Lability-Negativity, and Internalizing Symptomatology in Maltreated and Nonmaltreated Children. *Child Development*, *84*(2), 512–527. https://doi.org/10.1111/j.1467-8624.2012.01857.x

Kober, H., Buhle, J., Weber, J., Ochsner, K. N., & Wager, T. D. (2019). Let it be: mindful acceptance down-regulates pain and negative emotion. *Social Cognitive and Affective Neuroscience, 14*(11), 1147–1158. https://doi.org/10.1093/scan/nsz104

Kobulsky, J., Schroeder, K., Schuler, B., Patrick, E. L., Lang, Y., & Wu, J. (2023). Developmental Timing of Child Maltreatment in Relation to Obesity and Substance Use Disorder in Late Adolescence. *Psychology of Violence*. https://doi.org/10.1037/vio0000495

Kok, R. (2017). Emotion Regulation. In *Encyclopedia of Personality and Individual Differences* (pp. 1–10). Springer International Publishing. https://doi.org/10.1007/978-3-319-28099-8_811-1

Kong, S., & Bernstein, K. (2009). Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. *Journal of Clinical Nursing, 18*(13), 1897–1907. https://doi.org/10.1111/j.1365-2702.2008.02740.x

Kothari, R., Gafton, J., Treasure, J., & Micali, N. (2014). 2D:4D Ratio in children at familial high-risk for eating disorders: The role of prenatal testosterone exposure. *American Journal of Human Biology*, *26*(2), 176–182. https://doi.org/10.1002/ajhb.22495

Kovács-Tóth, B., Oláh, B., Kuritárné Szabó, I., & Túry, F. (2022). Adverse childhood experiences increase the risk for eating disorders among adolescents. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.1063693

Kraaij, V., Garnefski, N., Jan De Wilde, E., Dijkstra, A., Gebhardt, W., Maes, S., & Ter Doest, L. (2003). Negative Life Events and Depressive Symptoms in Late Adolescence: Bonding and Cognitive Coping as Vulnerability Factors? In *Journal of Youth and Adolescence* (Vol. 32, Issue 3).

Kurdak, H., Tiyekli, E., Özcan, S., Özer, Z. Y., & Nur Topuz, A. (2023). Eating disorders, primary care, and stigma: an analysis of research trends and patterns. *Frontiers in Psychiatry*, *14*. https://doi.org/10.3389/fpsyt.2023.1243922

Laessle, R. G., Tuschl, R. J., Kotthaus, B. C., & Pirke, K. M. (1989). A Comparison of the Validity of Three Scales for the Assessment of Dietary Restraint. In *Journal of Abnormal Psychology* (Vol. 98, Issue 4).

Lafrance Robinson, A., Kosmerly, S., Mansfield-Green, S., & Lafrance, G. (2014). Disordered eating behaviours in an undergraduate sample: Associations among gender, body mass index, and difficulties in emotion regulation. *Canadian Journal of Behavioural Science / Revue Canadienne Des Sciences Du Comportement, 46*(3), 320–326. https://doi.org/10.1037/a0031123

Lagan, S., Shott, M. E., & Frank, G. K. W. (2024). Adverse childhood experiences, low self-esteem, and salient stimulus response in eating disorders. *European Eating Disorders Review*, *32*(4), 618–632. https://doi.org/10.1002/erv.3064

Leppanen, J., Brown, D., McLinden, H., Williams, S., & Tchanturia, K. (2022). The Role of Emotion Regulation in Eating Disorders: A Network Meta-Analysis Approach. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.793094

Lev-Ari, L., Bachner-Melman, R., & Zohar, A. H. (2021a). Eating Disorder Examination Questionnaire (EDE-Q-13): expanding on the short form. *Journal of Eating Disorders*, *9*(1). https://doi.org/10.1186/s40337-021-00403-x

Lev-Ari, L., Bachner-Melman, R., & Zohar, A. H. (2021b). Eating Disorder Examination Questionnaire (EDE-Q-13): expanding on the short form. *Journal of Eating Disorders*, *9*(1). https://doi.org/10.1186/s40337-021-00403-x

Li, H., Han, W., Zhuang, S., Xu, J., Sun, Y., & Zheng, Z. (2024). *Childhood abuse and disordered eating behaviors in female college students: how does depression and anxiety come from?* https://doi.org/10.21203/rs.3.rs-3957634/v1

Li, J. C., Noll, J. G., Bensman, H. E., & Putnam, F. W. (2019). Childhood sexual abuse increases risks for eating disorder symptoms and eating disorder-related health problems in females. In *Child maltreatment research, policy, and practice: Contributions of Penelope K. Trickett* (pp. 11–26). Springer.

Lie, S. Ø., Bulik, C. M., Andreassen, O. A., Rø, Ø., & Bang, L. (2021). The association between bullying and eating disorders: A case–control study. *International Journal of Eating Disorders*, *54*(8), 1405–1414. https://doi.org/10.1002/eat.23522

Linardon, J. (2017). Correlates of the over-evaluation of weight and shape in binge eating disorder and mixed eating disorder samples: A meta-analytic review. *Eating Disorders*, *25*(3), 183–198. https://doi.org/10.1080/10640266.2016.1260374

Linardon, J., & Brennan, L. (2017). The effects of cognitive-behavioral therapy for eating disorders on quality of life: A meta-analysis. In *International Journal of Eating Disorders* (Vol. 50, Issue 7, pp. 715–730). John Wiley and Sons Inc. https://doi.org/10.1002/eat.22719

Linardon, J., Fairburn, C. G., Fitzsimmons-Craft, E. E., Wilfley, D. E., & Brennan, L. (2017). The empirical status of the third-wave behaviour therapies for the treatment of eating disorders: A systematic review. *Clinical Psychology Review*, *58*, 125–140. https://doi.org/10.1016/j.cpr.2017.10.005

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.

Lock, J. (2018). Family therapy for eating disorders in youth. *Current Opinion in Psychiatry*, *31*(6), 431–435. https://doi.org/10.1097/YCO.0000000000000451

Lozano-Madrid, M., Granero, R., Lucas, I., Sánchez, I., Sánchez-González, J., Gómez-Peña, M., Moragas, L., Mallorquí-Bagué, N., Tapia, J., Jiménez-Murcia, S., & Fernández-Aranda, F. (2023). Impulsivity and compulsivity in gambling disorder and bulimic spectrum eating disorders: Analysis of neuropsychological profiles and sex differences. *European Psychiatry*, *66*(1), e91. https://doi.org/10.1192/j.eurpsy.2023.2458

Machado, P. P. P., Grilo, C. M., Rodrigues, T. F., Vaz, A. R., & Crosby, R. D. (2020). Eating Disorder Examination – Questionnaire short forms: A comparison. *International Journal of Eating Disorders*, *53*(6), 937–944. https://doi.org/10.1002/eat.23275

Mann, H. (2024). dropout: an R Package for Addressing Dropouts, Missing Values, and Sectional Challenges in Survey Data Analysis. *Journal of Open Source Software*, *9*(95), 6181. https://doi.org/10.21105/joss.06181

Mansell, W., Harvey, A., Watkins, E., & Shafran, R. (2009). Conceptual foundations of the transdiagnostic approach to CBT. In *Journal of Cognitive Psychotherapy* (Vol. 23, Issue 1, pp. 6–19). Springer Publishing Company. https://doi.org/10.1891/0889-8391.23.1.6

Marc, B., & Hanafy, I. (2015). Children: Neglect. In *Encyclopedia of Forensic and Legal Medicine: Second Edition* (pp. 482–490). Elsevier Inc. https://doi.org/10.1016/B978-0-12-800034-2.00067-7

Mares, L. S., Davenport, R. A., & Kiropoulos, L. A. (2023). Adverse Childhood Experiences and Depression, Anxiety, and Eating Disorders: The Mediating Role of Intolerance of Uncertainty and Emotion Regulation Difficulty. *Traumatology*. https://doi.org/10.1037/trm0000442

Martin, R. C., & Dahlen, E. R. (2005). Cognitive emotion regulation in the prediction of depression, anxiety, stress, and anger. *Personality and Individual Differences*, *39*(7), 1249–1260. https://doi.org/10.1016/j.paid.2005.06.004

Martinussen, M., Friborg, • Oddgeir, Schmierer, P., Kaiser, S., Øvergård, K. T., Neunhoeffer, A.-L., Egil, •, Martinsen, W., & Rosenvinge, J. H. (2016). The comorbidity of personality disorders in eating disorders: a meta-analysis. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *22*. https://doi.org/10.1007/s40519-016-0345-x

Marusak, H. A., Martin, K. R., Etkin, A., & Thomason, M. E. (2015). Childhood Trauma Exposure Disrupts the Automatic Regulation of Emotional Processing. *Neuropsychopharmacology*, *40*, 1250–1258. https://doi.org/10.1038/npp.2014.311

Massullo, C., De Rossi, E., Carbone, G. A., Impera-Tori, C., Ardito, R. B., Adenzato, M., & Farina, B. (2023). CHILD MALTREATMENT, ABUSE, AND NEGLECT: AN UMBRELLA REVIEW OF THEIR PREVALENCE AND DEFINITIONS. *Clinical Neuropsychiatry*, *20*(2), 72–99. https://doi.org/10.36131/cnfioritieditore20230201

McLaughlin, K. A. (2016). Future Directions in Childhood Adversity and Youth Psychopathology. *Journal of Clinical Child and Adolescent Psychology*, *45*(3), 361–382. https://doi.org/10.1080/15374416.2015.1110823

McLaughlin, K. A., Aldao, A., Wisco, B. E., & Hilt, L. M. (2014). Rumination as a transdiagnostic factor underlying transitions between internalizing symptoms and aggressive behavior in early adolescents. *Journal of Abnormal Psychology*, *123*(1), 13–23. https://doi.org/10.1037/a0035358

McLaughlin, K. A., Colich, N. L., Rodman, A. M., & Weissman, D. G. (2020). Mechanisms linking childhood trauma exposure and psychopathology: A transdiagnostic model of risk and resilience. In *BMC Medicine* (Vol. 18, Issue 1). BioMed Central Ltd. https://doi.org/10.1186/s12916-020-01561-6

Messina, I., Grecucci, A., & Viviani, R. (2021). Neurobiological models of emotion regulation: a meta-analysis of neuroimaging studies of acceptance as an emotion regulation strategy. *Social Cognitive and Affective Neuroscience*, *16*(3), 257–267. https://doi.org/10.1093/scan/nsab007

Messman-Moore, T. L., & Bhuptani, P. H. (2017). A review of the long-term impact of child maltreatment on posttraumatic stress disorder and its comorbidities: An emotion dysregulation perspective. *Clinical Psychology: Science and Practice*, *24*(2), 154–169. https://doi.org/10.1111/cpsp.12193

Mihoc, I.-G., Dobrin, R.-P., Chiriță, R., Bejenariu, A., Gireadă, B., Tataru, A., Mihai, C., & Iliuță, F. P. (2024). The ugly truth about eating disorders. A case illustration of Anorexia Nervosa. *Bulletin of Integrative Psychiatry*, *101*(2), 141–149. https://doi.org/10.36219/BPI.2024.2.14

Miller, A. E., Trolio, V., Halicki-Asakawa, A., & Racine, S. E. (2022). Eating disorders and the nine symptoms of borderline personality disorder: A systematic review and series of meta-analyses. *International Journal of Eating Disorders*, *55*(8), 993–1011. https://doi.org/10.1002/eat.23731

Mills, R., Alati, R., Strathearn, L., & Najman, J. M. (2014). Alcohol and tobacco use among maltreated and non-maltreated adolescents in a birth cohort. *Addiction*, *109*(4), 672–680. https://doi.org/10.1111/add.12447

Milojevich, H. M., Norwalk, K. E., & Sheridan, M. A. (2019). Deprivation and threat, emotion dysregulation, and psychopathology: Concurrent and longitudinal associations. *Development and Psychopathology*, *31*(3), 847–857. https://doi.org/10.1017/S0954579419000294

Milovanović, I., Sadiković, S., & Kodžopeljić, J. (2018). Genetic and environmental factors in emotion regulation and life satisfaction: A twin study. *Primenjena Psihologija*, *11*(4), 399–417. https://doi.org/10.19090/pp.2018.4.399-417

Minnich, A. M., Gordon, K. H., Kwan, M. Y., & Troop-Gordon, W. (2017). Examining the mediating role of alexithymia in the association between childhood neglect and disordered eating behaviors in men and women. *Psychology of Men & Masculinity*, *18*(4), 414–421. https://doi.org/10.1037/men0000060

Mitchell, J. E., & Peterson, C. B. (2020). Anorexia Nervosa. *New England Journal of Medicine*, *382*(14), 1343–1351. https://doi.org/10.1056/NEJMcp1803175

Molendijk, M. L., Hoek, H. W., Brewerton, T. D., & Elzinga, B. M. (2017). Childhood maltreatment and eating disorder pathology: A systematic review and dose-response meta-analysis. *Psychological Medicine*, *47*(8), 1402–1416. https://doi.org/10.1017/S0033291716003561

Monell, E., Clinton, D., & Birgegård, A. (2018). Emotion dysregulation and eating disorders—Associations with diagnostic presentation and key symptoms. *International Journal of Eating Disorders*, *51*(8), 921–930. https://doi.org/10.1002/eat.22925

Moody, G., Cannings-John, R., Hood, K., Kemp, A., & Robling, M. (2018). Establishing the international prevalence of self-reported child maltreatment: a systematic review by maltreatment type and gender. *BMC Public Health*, *18*(1164), 1–15. https://doi.org/10.1186/s12889-018-6044-y

Moulton, S. J., Newman, E., Power, K., Swanson, V., & Day, K. (2015). Childhood trauma and eating psychopathology: A mediating role for dissociation and emotion dysregulation? *Child Abuse & Neglect*, *39*, 167–174. https://doi.org/10.1016/j.chiabu.2014.07.003

Moussa Rogers, M., & McKinney, C. (2019). Emerging Adult Risky Sexual Behavior Predicted by Parental Overprotection: Moderated Mediation Analysis. *Family Process*, *58*(4), 972–985. https://doi.org/10.1111/famp.12394

Mumtaz, S., Farhat, S. M., Saeed, R. F., Younis, S., & Ali, M. (2022). Binge eating disorder during COVID-19. *Open Life Sciences*, *17*(1), 321–322. https://doi.org/10.1515/biol-2022-0033

Musetti, A., Gagliardini, G., Lenzo, V., & Cella, S. (2023). Supplemental Material for From Childhood Emotional Maltreatment to Disordered Eating: A Path Analysis. *Psychoanalytic Psychology*. https://doi.org/10.1037/pap0000438.supp

Mustelin, L., Lehtokari, V., & Keski-Rahkonen, A. (2016). Other specified and unspecified feeding or eating disorders among women in the community.

International Journal of Eating Disorders, *49*(11), 1010–1017. https://doi.org/10.1002/eat.22586

Nagata, J. M., Smith-Russack, Z., Paul, A., Saldana, G. A., Shao, I. Y., Al-Shoaibi, A. A. A., Chaphekar, A. V., Downey, A. E., He, J., Murray, S. B., Baker, F. C., & Ganson, K. T. (2023). The social epidemiology of binge-eating disorder and behaviors in early adolescents. *Journal of Eating Disorders*, *11*(1), 182. https://doi.org/10.1186/s40337-023-00904-x

National Collaborating Centre for Mental Health (UK). (2004). *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders*.

Naydenova, D., & Eyubova, S. (2022). A case report of an early onset of anorexia nervosa. *Scripta Scientifica Medica*, *54*(0), 84. https://doi.org/10.14748/ssm.v54i0.9014

Nelson, J., Klumparendt, A., Doebler, P., & Ehring, T. (2017). Childhood maltreatment and characteristics of adult depression: meta-analysis. *The British Journal of Psychiatry*, *201*, 96–104. https://doi.org/10.1192/bjp.bp.115.180752

Nolen-Hoeksema, S., Stice, E., Wade, E., & Bohon, C. (2007). Reciprocal relations between rumination and bulimic, substance abuse, and depressive symptoms in female adolescents. *Journal of Abnormal Psychology*, *116*(1), 198–207. https://doi.org/10.1037/0021-843X.116.1.198

Nolen-Hoeksema, S., & Watkins, E. R. (2011). A heuristic for developing transdiagnostic models of psychopathology: Explaining multifinality and divergent trajectories. *Perspectives on Psychological Science*, *6*(6), 589–609. https://doi.org/10.1177/1745691611419672

Ogorenko, V., & Kokashynskyi, V. (2023). Effectiveness of correction of eating disorders in anxiety-depressive disorders. *Psychosomatic Medicine and General Practice*, *8*(3). https://doi.org/10.26766/PMGP.V8I3.447

Olariike Oyindasola, K., Funke Adedoyin, F., & Adeyemi Adedoyin, A. (2022). Anorexia Nervosa: Opportunities and Challenges in Treatment. In *Weight Management - Challenges and Opportunities*. IntechOpen. https://doi.org/10.5772/intechopen.103751

O'Loghlen, E., Galligan, R., & Grant, S. (2023). Childhood maltreatment, shame, psychological distress, and binge eating: testing a serial mediational model. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00819-7

Otani, K., Suzuki, A., Matsumoto, Y., Shibuya, N., Sadahiro, R., & Enokido, M. (2013). *Parental overprotection engenders dysfunctional attitudes about achievement and dependency in a gender-specific manner*. http://www.biomedcentral.com/1471-244X/13/345

Overall, J. (2019). *The Alchemy of Acceptance: How Accepting Emotions Enhances the Ability to Flexibly Work with Them"* [Master of Applied Positive Psychology (MAPP) Capstone Projects]. https://repository.upenn.edu/mapp_capstonehttps://repository.upenn.edu/mapp_capstone/185

Overton, A., Selway, S., Strongman, K., & Houston, M. (2005). Eating Disorders?The Regulation of Positive as well as Negative Emotion Experience. *Journal of Clinical Psychology in Medical Settings*, *12*(1), 39–56. https://doi.org/10.1007/s10880-005-0911-2

Pignatelli, A. M., Wampers, M., Loriedo, C., Biondi, M., & Vanderlinden, J. (2017). Childhood neglect in eating disorders: A systematic review and meta-analysis. In *Journal of Trauma and Dissociation* (Vol. 18, Issue 1, pp. 100–115). Routledge. https://doi.org/10.1080/15299732.2016.1198951

Pike, K. M., Wilfley, D., Hilbert, A., Fairburn, C. G., Dohm, F.-A., & Striegel-Moore, R. H. (2006). Antecedent life events of binge-eating disorder. *Psychiatry Research*, *142*(1), 19–29. https://doi.org/10.1016/j.psychres.2005.10.006

Pinson, C. K., & Frank, G. K. W. (2024). Why Don't You Just Eat? Neuroscience and the Enigma of Eating Disorders. *Focus*, *22*(3), 328–332. https://doi.org/10.1176/appi.focus.20240006

Prefit, A.-B., Cândea, D. M., & Szentagotai-Tătar, A. (2019). Emotion regulation across eating pathology: A meta-analysis. *Appetite*, *143*, 104438. https://doi.org/10.1016/j.appet.2019.104438

Pretorius, C., Walker, S. P., & Esterhuyse, K. G. F. (2010). Coping responses as predictors of satisfaction with life amongst a group of patients diagnosed with diabetes mellitus. *Health SA Gesondheid*, *15*(1). https://doi.org/10.4102/hsag.v15i1.513

Proctor, L. J., Lewis, T., Roesch, S., Thompson, R., Litrownik, A. J., English, D., Arria, A. M., Isbell, P., & Dubowitz, H. (2017). Child maltreatment and age of alcohol and marijuana initiation in high-risk youth. *Addictive Behaviors*, *75*, 64–69. https://doi.org/10.1016/j.addbeh.2017.06.021

Pruccoli, J., & Parmeggiani, A. (2023). Early onset anorexia nervosa: Multidisciplinary hospital intervention in a 1-year follow-up study. *Early Intervention in Psychiatry*, *17*(10), 992–1000. https://doi.org/10.1111/eip.13392

Puttevils, L., Vanderhasselt, M.-A., Horczak, P., & Vervaet, M. (2021). Differences in the use of emotion regulation strategies between anorexia and bulimia nervosa: A systematic review and meta-analysis. *Comprehensive Psychiatry*, *109*, 152262. https://doi.org/10.1016/j.comppsych.2021.152262

Qian, J., Wu, Y., Liu, F., Zhu, Y., Jin, H., Zhang, H., Wan, Y., Li, C., & Yu, D. (2022). An update on the prevalence of eating disorders in the general population: a systematic review and meta-analysis. In *Eating and Weight Disorders* (Vol. 27, Issue 2, pp. 415–428). Springer Science and Business Media Deutschland GmbH. https://doi.org/10.1007/s40519-021-01162-z

Quadflieg, N., Voderholzer, U., Meule, A., & Fichter, M. M. (2023). Comparing ICD-11 and DSM-5 eating disorder diagnoses with the Munich eating and feeding disorder questionnaire (ED-Quest). *International Journal of Eating Disorders*, *56*(9), 1826–1831. https://doi.org/10.1002/EAT.24010

Rabito-Alcón, M. F., Baile, J. I., & Vanderlinden, J. (2021). Mediating factors between childhood traumatic experiences and eating disorders development: A systematic review. In *Children* (Vol. 8, Issue 2). MDPI. https://doi.org/10.3390/children8020114

Racine, S. E., & Wildes, J. E. (2015). Emotion dysregulation and anorexia nervosa: An exploration of the role of childhood abuse. *International Journal of Eating Disorders*, *48*(1), 55–58. https://doi.org/10.1002/eat.22364

Ranzenhofer, L. M., Jablonski, M., Davis, L., Posner, J., Walsh, B. T., & Steinglass, J. E. (2022). Early Course of Symptom Development in Anorexia Nervosa. *Journal of Adolescent Health*, *71*(5), 587–593. https://doi.org/10.1016/j.jadohealth.2022.06.010

Reas, D. L., Williamson, D. A., Martin, C. K., & Zucker, N. L. (2000). Duration of illness predicts outcome for bulimia nervosa: A long-term follow-up study. *International Journal of Eating Disorders*, *27*(4), 428–434. https://doi.org/10.1002/(SICI)1098-108X(200005)27:4<428::AID-EAT7>3.0.CO;2-Y

Rijkers, C., Schoorl, M., van Hoeken, D., & Hoek, H. W. (2019). Eating disorders and posttraumatic stress disorder. *Current Opinion in Psychiatry*, *32*(6), 510–517.

Rodgers, R., Chabrol, H., & Paxton, S. J. (2011). An exploration of the tripartite influence model of body dissatisfaction and disordered eating among Australian and French college women. *Body Image*, *8*(3), 208–215. https://doi.org/10.1016/j.bodyim.2011.04.009

Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of Eating Disorders*, *48*(2), 187–198. https://doi.org/10.1002/eat.22270

Rossi, E., Cassioli, E., Dani, C., Marchesoni, G., Monteleone, A. M., Wonderlich, S. A., Ricca, V., & Castellini, G. (2024). The maltreated eco-phenotype of eating disorders: A new diagnostic specifier? A systematic review of the evidence and comprehensive

description. In *Neuroscience and Biobehavioral Reviews* (Vol. 160). Elsevier Ltd. https://doi.org/10.1016/j.neubiorev.2024.105619

Rowsell, M., MacDonald, D. E., & Carter, J. C. (2016). Emotion regulation difficulties in anorexia nervosa: associations with improvements in eating psychopathology. *Journal of Eating Disorders*, *4*(1), 17. https://doi.org/10.1186/s40337-016-0108-0

Rozakou-Soumalia, N., Dârvariu, Ş., & Sjögren, J. M. (2021). Dialectical Behaviour Therapy Improves Emotion Dysregulation Mainly in Binge Eating Disorder and Bulimia Nervosa: A Systematic Review and Meta-Analysis. *Journal of Personalized Medicine*, *11*(9), 931. https://doi.org/10.3390/jpm11090931

Santos, B. M., & Haynos, A. F. (2023). Difficulties with positive emotion regulation in anorexia nervosa. *European Eating Disorders Review*, *31*(4), 520–528. https://doi.org/10.1002/erv.2973

Şar, V., Necef, I., Mutluer, T., Fatih, P., & Türk-Kurtça, T. (2021). A Revised And Expanded Version Of The Turkish Childhood Trauma Questionnaire (CTQ-33): Overprotection-Overcontrol As Additional Factor. *Journal of Trauma and Dissociation*, *22*(1), 35–51. https://doi.org/10.1080/15299732.2020.1760171

Şar, V., Öztürk, E., & Ikikardeş, E. (2012). Validity and reliability of the Turkish version of Childhood Trauma Questionnaire. *Turkiye Klinikleri Journal of Medical Sciences*, *32*(4), 1054–1063. https://doi.org/10.5336/medsci.2011-26947

Schmidt, U., & Treasure, J. (2006). Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical Psychology*, *45*(3), 343–366. https://doi.org/10.1348/014466505X53902

Schreier, H. M. C., Kuras, Y. I., McInnis, C. M., Thoma, M. V., St Pierre, D. G., Hanlin, L., Chen, X., Wang, D., Goldblatt, D., & Rohleder, N. (2020). Childhood Physical Neglect Is Associated With Exaggerated Systemic and Intracellular Inflammatory Responses to Repeated Psychosocial Stress in Adulthood. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.00504

Schroeder, K., Schuler, B. R., Kobulsky, J. M., & Sarwer, D. B. (2021). The association between adverse childhood experiences and childhood obesity: A systematic review. *Obesity Reviews*, *22*(7). https://doi.org/10.1111/obr.13204

Scrandis, D. A., & Arnow, D. (2023). Binge-eating disorder. *The Nurse Practitioner*, *48*(12), 22–28. https://doi.org/10.1097/01.NPR.0000000000000125

Sigurvinsdottir, R., Ullman, S. E., & Canetto, S. S. (2020). Self-blame, psychological distress, and suicidality among African American female sexual assault survivors. *Traumatology*, *26*(1), 1–10. https://doi.org/10.1037/trm0000195

Silén, Y., & Keski-Rahkonen, A. (2022). Worldwide prevalence of DSM-5 eating disorders among young people. In *Current Opinion in Psychiatry* (Vol. 35, Issue 6, pp. 362–371). Lippincott Williams and Wilkins. https://doi.org/10.1097/YCO.0000000000000818

Singh, S., & Gadiraju, P. (2020). Prevalence and correlates of body dissatisfaction and disordered eating patterns in Indian youth: The role of media. *Indian Journal of Psychiatry*, *62*(5), 509. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_737_19

Smith, K. E., Mason, T. B., Anderson, N. L., & Lavender, J. M. (2019). Unpacking cognitive emotion regulation in eating disorder psychopathology: The differential relationships between rumination, thought suppression, and eating disorder symptoms among men and women. *Eating Behaviors*, *32*, 95–100. https://doi.org/10.1016/j.eatbeh.2019.01.003

Smolak, L., & Murnen, S. K. (2002). A meta-analytic examination of the relationship between child sexual abuse and eating disorders. *International Journal of Eating Disorders*, *31*(2), 136–150. https://doi.org/10.1002/eat.10008

Sofuoğlu, Z., Sarıyer, G., & Ataman, M. G. (2016). Child Maltreatment in Turkey: Comparison of Parent and Child Reports. *Central European Journal of Public Health*, *24*(3), 217–222. https://doi.org/10.21101/cejph.a4155

Solmi, M., Radua, J., Stubbs, B., Ricca, V., Moretti, D., Busatta, D., Carvalho, A. F., Dragioti, E., Favaro, A., Monteleone, A. M., Shin, J. Il, Fusar-Poli, P., & Castellini, G. (2021). Risk factors for eating disorders: an umbrella review of published meta-analyses. In *Brazilian Journal of Psychiatry* (Vol. 43, Issue 3, pp. 314–323). Associacao Brasileira de Psiquiatria. https://doi.org/10.1590/1516-4446-2020-1099

Solmi, M., Wade, T. D., Byrne, S., Del Giovane, C., Fairburn, C. G., Ostinelli, E. G., De Crescenzo, F., Johnson, C., Schmidt, U., Treasure, J., Favaro, A., Zipfel, S., & Cipriani, A. (2021). Comparative efficacy and acceptability of psychological interventions for the treatment of adult outpatients with anorexia nervosa: a systematic review and network meta-analysis. *The Lancet Psychiatry*, *8*(3), 215–224. https://doi.org/10.1016/S2215-0366(20)30566-6

Son, E., & Kwon, K. H. (2024). The impact of excessive dieting on eating disorders in adolescent women: a literature review. In *Nutrition and Food Science* (Vol. 54, Issue 2, pp. 366–376). Emerald Publishing. https://doi.org/10.1108/NFS-06-2023-0127

Sonneville, K. R., & Lipson, S. K. (2018). Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *International Journal of Eating Disorders*, *51*(6), 518–526. https://doi.org/10.1002/eat.22846

Spokas, M., & Heimberg, R. G. (2009). Overprotective parenting, social anxiety, and external locus of control: Cross-sectional and longitudinal relationships. *Cognitive Therapy and Research*, *33*(6), 543–551. https://doi.org/10.1007/s10608-008-9227-5

St-Hilaire, A., Steiger, H., Liu, A., Laplante, D. P., Thaler, L., Magill, T., & King, S. (2015). A prospective study of effects of prenatal maternal stress on later eating-disorder manifestations in affected offspring: Preliminary indications based on the project ice storm cohort. *International Journal of Eating Disorders*, *48*(5), 512–516. https://doi.org/10.1002/eat.22391

Stice, E., Gau, J. M., Rohde, P., & Shaw, H. (2017). Risk factors that predict future onset of each DSM-5 eating disorder: Predictive specificity in high-risk adolescent females. *Journal of Abnormal Psychology*, *126*(1), 38–51. https://doi.org/10.1037/abn0000219

Stice, E., Marti, C. N., Shaw, H., & Rohde, P. (2019). Meta-Analytic Review of Dissonance-Based Eating Disorder Prevention Programs: Intervention, Participant, and Facilitator Features that Predict Larger Effects HHS Public Access. *Clin Psychol Rev*, *70*, 91–107. https://doi.org/10.1016/j.cpr.2019.04.004

Sugiura, M., Katayori, Y., Muratsubaki, T., Shiratori, M., Hanawa, S., Nejad, K. K., Tamura, D., Kawashima, R., & Fukudo, S. (2023). Automatic adaptive emotion regulation is associated with lower emotion-related activation in the frontoparietal cortex and other cortical regions with multi-componential organization. *Frontiers in Behavioral Neuroscience*, *17*. https://doi.org/10.3389/fnbeh.2023.1059158

Svaldi, J., Griepenstroh, J., Tuschen-Caffier, B., & Ehring, T. (2012). Emotion regulation deficits in eating disorders: A marker of eating pathology or general psychopathology? *Psychiatry Research*, *197*(1–2), 103–111. https://doi.org/10.1016/J.PSYCHRES.2011.11.009

Talmon, A., & Widom, C. S. (2022). Childhood Maltreatment and Eating Disorders: A Prospective Investigation. *Child Maltreatment*, *27*(1), 88–99. https://doi.org/10.1177/1077559520988786

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral Emotions and Moral Behavior. *Annual Review of Psychology*, *58*(1), 345–372. https://doi.org/10.1146/annurev.psych.56.091103.070145

Teicher, M. H., Samson, J. A., Anderson, C. M., & Ohashi, K. (2016). The effects of childhood maltreatment on brain structure, function and connectivity. *Nature Reviews Neuroscience*, *17*(10), 652–666. https://doi.org/10.1038/nrn.2016.111

Thompson, R. A. (1991). Emotional Regulation and Emotional Development. In *Educational Psychology Review* (Vol. 3, Issue 4).

Thompson, R. A. (1994). Emotion Regulation: A Theme in Search of Definition. *Society for Research in Child Development*, *59*(2/3), 25–52.

Thornton, L. M., Mazzeo, S. E., & Bulik, C. M. (2010). *The Heritability of Eating Disorders: Methods and Current Findings* (pp. 141–156). https://doi.org/10.1007/7854_2010_91

Tilstra-Ferrell, E. L., Redondo, R. A., Russin, S. E., & Braden, A. (2023). Emotion regulation difficulties, child sexual, physical, and emotional abuse and emotional eating. *Journal of Family Trauma, Child Custody & Child Development*, *20*(4), 389–409. https://doi.org/10.1080/26904586.2022.2066597

Tobin, L. N., Lacroix, E., & von Ranson, K. M. (2019). Evaluating an abbreviated three-factor version of the Eating Disorder Examination Questionnaire in three samples. *Eating Behaviors*, *32*, 18–22. https://doi.org/10.1016/j.eatbeh.2018.11.003

Treasure, J., Hübel, C., & Himmerich, H. (2022). The evolving epidemiology and differential etiopathogenesis of eating disorders: implications for prevention and treatment. *World Psychiatry*, *21*(1), 147–148. https://doi.org/10.1002/wps.20935

Trompeter, N., Bussey, · Kay, Forbes, M. K., & Mitchison, D. (2021). Emotion Dysregulation within the CBT-E Model of Eating Disorders: A Narrative Review. *Cognitive Therapy and Research*, *45*, 1021–1036. https://doi.org/10.1007/s10608-021-10225-5

Trottier, K., & MacDonald, D. E. (2017a). Update on Psychological Trauma, Other Severe Adverse Experiences and Eating Disorders: State of the Research and Future Research Directions. In *Current Psychiatry Reports* (Vol. 19, Issue 8). Current Medicine Group LLC 1. https://doi.org/10.1007/s11920-017-0806-6

Trottier, K., & MacDonald, D. E. (2017b). Update on Psychological Trauma, Other Severe Adverse Experiences and Eating Disorders: State of the Research and Future Research Directions. *Current Psychiatry Reports*, *19*(8), 45. https://doi.org/10.1007/s11920-017-0806-6

Tuckwell, H. C. (2024). Treatment of addictions with special reference to anorexia nervosa. *Journal of Multiscale Neuroscience*, *3*(2), 88–93. https://doi.org/10.56280/1620173955

Tuna, E., & Bozo, Ö. (2012). The cognitive emotion regulation questionnaire: Factor structure and psychometric properties of the turkish version. *Journal of Psychopathology and Behavioral Assessment*, *34*(4), 564–570. https://doi.org/10.1007/s10862-012-9303-8

Uhlhaas, P. J., Davey, C. G., Mehta, U. M., Shah, J., Torous, J., Allen, N. B., Avenevoli, S., Bella-Awusah, T., Chanen, A., Chen, E. Y. H., Correll, C. U., Do, K. Q., Fisher, H. L., Frangou, S., Hickie, I. B., Keshavan, M. S., Konrad, K., Lee, F. S., Liu, C. H.,

… Wood, S. J. (2023). Towards a youth mental health paradigm: a perspective and roadmap. In *Molecular Psychiatry* (Vol. 28, Issue 8, pp. 3171–3181). Springer Nature. https://doi.org/10.1038/s41380-023-02202-z

Ulfvebrand, S., Birgegård, A., Norring, C., Högdahl, L., & von Hausswolff-Juhlin, Y. (2015). Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. *Psychiatry Research*, *230*(2), 294–299. https://doi.org/https://doi.org/10.1016/j.psychres.2015.09.008

Ulukol, B., Kahilogullari, A., Sethi, D., Guney, S. V., Odek, O. B., Parin, S., Yopbas, M., Aksit, S., Koc, F. U., Kose, K., & Can, G. (2016). 470 Adverse childhood experiences study among university students in Turkey. *Child Maltreatment*, A171.1-A171. https://doi.org/10.1136/injuryprev-2016-042156.470

Usmani, S. S., Saboor, S., Musavi, N. B., Liaqat, S., Ansari, A., & Zeshan, M. (2022). 2.37 The Association Between Parenting Styles and Eating Disorders: A Scoping Review. *Journal of the American Academy of Child & Adolescent Psychiatry*, *61*(10), S194. https://doi.org/10.1016/j.jaac.2022.09.181

Ustuner Top, F., & Cam, H. H. (2021). Childhood maltreatment among university students in Turkey: prevalence, demographic factors, and health-related quality of life consequences. *Psychology, Health and Medicine*, *26*(5), 543–554. https://doi.org/10.1080/13548506.2020.1768274

Vajda, A., & Láng, A. (2014). Emotional Abuse, Neglect in Eating Disorders and their Relationship with Emotion Regulation. *Procedia - Social and Behavioral Sciences*, *131*, 386–390. https://doi.org/10.1016/j.sbspro.2014.04.135

van Beugen, S., van Middendorp, H., Ferwerda, M., Smit, J. V., Zeeuwen-Franssen, M. E. J., Kroft, E. B. M., de Jong, E. M. G. J., Donders, A. R. T., van de Kerkhof, P. C. M., & Evers, A. W. M. (2017). Predictors of perceived stigmatization in patients with psoriasis. *British Journal of Dermatology*, *176*(3), 687–694. https://doi.org/10.1111/bjd.14875

Van Hoeken, D., & Hoek, H. W. (2020). Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden. *Wolters Kluwer Health*, *33*(6), 521–527. https://doi.org/10.1097/YCO.0000000000000641

Verschueren, M., Palmeroni, N., Raemen, L., Buelens, T., Moons, P., & Luyckx, K. (2021). Identity Functioning and Eating Disorder Symptomatology: The Role of Cognitive Emotion Regulation Strategies. *Frontiers in Psychology | Www.Frontiersin.Org*, *1*, 667235. https://doi.org/10.3389/fpsyg.2021.667235

Versini, A., Ramoz, N., Le Strat, Y., Scherag, S., Ehrlich, S., Boni, C., Hinney, A., Hebebrand, J., Romo, L., Guelfi, J.-D., & Gorwood, P. (2010). Estrogen Receptor 1 Gene (ESR1) is Associated with Restrictive Anorexia Nervosa. *Neuropsychopharmacology*, *35*(8), 1818–1825. https://doi.org/10.1038/npp.2010.49

Volpe, U., Tortorella, A., Manchia, M., Monteleone, A. M., Albert, U., & Monteleone, P. (2016). Eating disorders: What age at onset? *Psychiatry Research*, *238*, 225–227. https://doi.org/10.1016/j.psychres.2016.02.048

von Bertalanffy, L. (1968). General Systems Theory as Integrating Factor in Contemporary Science. In *Akten des XIV. Internationalen Kongresses für Philosophie* (pp. 335–340). Herder & Co. https://doi.org/10.5840/wcp1419682120

Walenda, A., Bogusz, K., Kopera, M., Jakubczyk, A., Wojnar, M., & Kucharska, K. (2021). Emotion regulation in binge eating disorder. *Psychiatria Polska*, *55*(6), 1433–1448. https://doi.org/10.12740/PP/ONLINEFIRST/122212

Wang, H., Xu, S., Wang, S., Wang, Y., & Chen, R. (2024). Using decision tree to predict non-suicidal self-injury among young adults: the role of depression, childhood maltreatment and recent bullying victimization. *European Journal of Psychotraumatology*, *15*(1). https://doi.org/10.1080/20008066.2024.2322390

Wang, Q., Fang, Y., Huang, H., Lv, W., Wang, X., Yang, T., Yuan, J., Gao, Y., Qian, R., & Zhang, Y. (2021). Anxiety, depression and cognitive emotion regulation strategies in Chinese nurses during the COVID-19 outbreak. *Journal of Nursing Management*, *29*(5), 1263–1274. https://doi.org/10.1111/jonm.13265

Wassenaar, E., Friedman, J., & Mehler, P. S. (2019). Medical Complications of Binge Eating Disorder. *Psychiatric Clinics of North America*, *42*(2), 275–286. https://doi.org/https://doi.org/10.1016/j.psc.2019.01.010

Watson, H. J., Thornton, L. M., Yilmaz, Z., Baker, J. H., Coleman, J. R. I., Adan, R. A. H., Alfredsson, L., Andreassen, O. A., Ask, H., Berrettini, W. H., Boehnke, M., Boehm, I., Boni, C., Buehren, K., Bulant, J., Burghardt, R., Chang, X., Cichon, S., Cone, R. D., … Bulik, C. M. (2022). Common Genetic Variation and Age of Onset of Anorexia Nervosa. *Biological Psychiatry Global Open Science*, *2*(4), 368–378. https://doi.org/10.1016/j.bpsgos.2021.09.001

Watts-English, T., Fortson, B. L., Gibler, N., Hooper, S. R., & De Bellis, M. D. (2006). The Psychobiology of Maltreatment in Childhood. *Journal of Social Issues*, *62*(4), 717–736. https://doi.org/10.1111/j.1540-4560.2006.00484.x

Waxman, S. E. (2009). A systematic review of impulsivity in eating disorders. *European Eating Disorders Review*, *17*(6), 408–425. https://doi.org/10.1002/erv.952

Westmoreland, P., Krantz, M. J., & Mehler, P. S. (2016). Medical Complications of Anorexia Nervosa and Bulimia. In *American Journal of Medicine* (Vol. 129, Issue 1, pp. 30–37). Elsevier Inc. https://doi.org/10.1016/j.amjmed.2015.06.031

Westmoreland, P., Mehler, P., & Brandt, H. (2022). Terminal Anorexia Is Dangerous Justification for Aid in Dying. *Psychiatric News*, *57*(11). https://doi.org/10.1176/appi.pn.2022.11.9.4

Willmore, J., Marko, T. L., Taing, D., & Sampasa-Kanyinga, H. (2017). The burden of alcohol-related morbidity and mortality in Ottawa, Canada. *PLoS ONE*, *12*(9). https://doi.org/10.1371/journal.pone.0185457

Witcher, D. B., & Williamson, D. A. (1992). Duration of bulimia nervosa and symptom progression: A retrospective analysis of treatment-seeking bulimics. *Journal of Substance Abuse*, *4*(3), 255–261. https://doi.org/10.1016/0899-3289(92)90034-U

World Health Organization. (1995). *Moderate and severe thinness, underweight, overweight, obesity*.

World Health Organization. (2024). *Clinical Descriptions and Diagnostic requirements for ICD-11 Mental, Behavioural and Neurodevelopmental disorders*.

World Health Organization (WHO). (2022, October 19). *Child maltreatment*. Https://Www.Who.Int/News-Room/Fact-Sheets/Detail/Child-Maltreatment.

World Health Organization (WHO). (2023, October 8). *Preventing child maltreatment*.

Xiao, C., Ye, J., Esteves, R. M., & Rong, C. (2016). Using Spearman's correlation coefficients for exploratory data analysis on big dataset. *Concurrency and Computation: Practice and Experience*, *28*(14), 3866–3878. https://doi.org/10.1002/cpe.3745

Xintong, X. (2023). Pathogenesis of anorexia nervosa. *SHS Web of Conferences*, *171*, 01005. https://doi.org/10.1051/shsconf/202317101005

Ylitervo, L., Veijola, J., & Halt, A.-H. (2023). Emotional neglect and parents' adverse childhood events. *European Psychiatry*, *66*(1). https://doi.org/10.1192/j.eurpsy.2023.2420

Zeeck, A., Stelzer, N., Linster, H. W., Joos, A., & Hartmann, A. (2011). Emotion and eating in binge eating disorder and obesity. *European Eating Disorders Review*, *19*(5), 426–437. https://doi.org/10.1002/erv.1066

Zhou, H. Y., Zhou, L., Zheng, T. X., Ma, L. P., Fan, M. X., Liu, L., Zhao, X. D., & Yan, C. (2024). Unraveling the link between childhood maltreatment and depression: Insights from the role of ventral striatum and middle cingulate cortex in hedonic experience and emotion regulation. *Development and Psychopathology*. https://doi.org/10.1017/S0954579423001591

Zlomke, K. R., & Hahn, K. S. (2010). Cognitive emotion regulation strategies: Gender differences and associations to worry. *Personality and Individual Differences*, *48*(4), 408–413. https://doi.org/10.1016/j.paid.2009.11.007

APPENDIXES

APPENDIX A

RESULTS OF MEDIATION ANALYSES

Table A.1. Mediating Role of Maladaptive CERS

Independent Variable	Unique Effect of IV on the Mediator (a)	Unique Effect of the Mediator on DV (b)	Direct Effect of IV on DV (c')	Indirect Effect (a1b1)	BC 95% CI	
					Lower	Upper
CM (Total)	.26 (.04)***	.22 (.08)**	.16 (.06)**	.06 (.02)**	.01	.10
CSA	.67 (.22)**	.28 (.07)***	.35 (.32)	.19 (.07)**	.06	.35
CEN	.88 (.13)***	.25 (.08)**	.36 (.21)*	.22 (.08)**	.06	.38
CPA	.59 (.22)**	.27 (.07)***	.79 (.30)**	.16 (.07)**	.04	.32
CEA	1.17 (.14)***	.23 (.08)**	.50 (.22)**	.27 (.11)**	.05	.47
CPN	.56 (.22)**	.28 (.07)***	.60 (.31)**	.16 (.07)**	.04	.30
OP-OC	.96 (.14)***	.24 (.08)**	.48 (.21)**	.23(.08) **	.06	.39

Note. In this table, the mediator signifies maladaptive cognitive emotion regulation strategies. DV signifies the total score of eating disorders. CM (Total) = Total score gained from CTQ-33; CSA=Childhood sexual abuse; CEN=Childhood emotional abuse; CPA=Childhood physical abuse; CEA=Childhood emotional abuse; CPN=Childhood physical neglect; OP-OC=Overprotection-overcontrol

* $p < .10$; ** $p < .05$; *** $p < .001$

Table A.2. Mediating Role of Adaptive CERS

Independent Variable	Unique Effect of IV on the Mediator (a)	Unique Effect of the Mediator on DV (b)	Direct Effect of IV on DV (c')	Indirect Effect (a1b1)	BC 95% CI	
					Lower	Upper
CM (Total)	-.10 (.03)**	.06 (.09)	.22 (.06)***	-.01 (.01)	-.03	.02
CSA	-.25 (.18)	.01 (.10)	.55(.32)*	-.002 (.03)	-.07	.06
CEN	-.49 (.11)**	.063(.096)	.61 (.20)**	-.031(.05)	-.14	.07
CPA	-.14 (.17)	.01 (.09)	.95 (.30)**	-.001 (.02)	-.05	.05
CEA	-.29 (.12)**	.04 (.09)	.78 (.21)***	-.01 (.03)	-.08	.05
CPN	-.26 (.18)	.02 (.09)	.76 (.31)**	-.003 (.03)	-.07	.06
OP-OC	-.37 (.12)***	.05 (.10)	.72 (.21)***	-.02 (.04)	-.11	.05

Note. In this table, the mediator signifies adaptive cognitive emotion regulation strategies. DV signifies the total score of eating disorders. CM (Total) = Total score gained from CTQ-33; CSA=Childhood sexual abuse; CEN=Childhood emotional abuse; CPA=Childhood physical abuse; CEA=Childhood emotional abuse; CPN=Childhood physical neglect; OP-OC= Parental overprotection-overcontrol

* $p < .10$; ** $p < .05$; *** $p < .001$

APPENDIX B

DATA COLLECTION TOOLS

Table B.1. Sociodemographic Form

SOSYODEMOGRAFİK FORM							
1	Cinsiyetiniz:						
	Kadın	Erkek	Diğer (Lütfen Belirtin): ……				
2	Lütfen aşağıdaki boşluğa doğum yılınızı yazınız.						
	……						
3	Lütfen eğitim seviyenizi belirtiniz.						
	İlkokul	Ortaokul	Lise	Önlisans	Lisans	Yüksek Lisans	Doktora
4	Şu an bir işte çalışıyor musunuz?						
	Evet.	Hayır.					
5	Lütfen gelir durumunuzu belirtiniz.						
	Alt	Alt-Orta	Orta	Orta-Üst	Üst		
6	Lütfen medeni durumunuzu belirtiniz.						
	Bekar	Evli	İlişkisi var.	Boşanmış.	Diğer (Lütfen belirtiniz): ……		
7	Lütfen kilonuzu kilogram cinsinden yazınız. (Emin değilseniz, en yakın tahmini yapınız.)						
	…… kg						
8	Lütfen boyunuzu santimetre cinsinden yazınız. (Emin değilseniz, en yakın tahmini yapınız.)						
	…… cm						
9	Daha önce yeme bozukluğu dışında bir psikolojik rahatsızlık tanısı aldınız mı?						
	Hayır.	Evet (lütfen hangi tanıyı aldığınızı belirtiniz): ……					
10	Daha önce bir yeme bozukluğu tanısı aldınız mı?						
	Hayır.	Evet (lütfen hangi tanıyı aldığınızı belirtiniz): ……					
11	Daha önce yeme bozukluğuna yönelik bir tedavi gördünüz mü?						
	Hayır.	Evet (Hala tedaviniz devam ediyor mu? - Lütfen boşluğa "evet" veya "hayır" şeklinde belirtin.): ……					

Table B.2. Childhood Trauma Questionnaire (CTQ-33)

ÇOCUKLUK ÇAĞI TRAVMALARI ÖLÇEĞİ						
	Her bir madde için aşağıdaki seçeneklerden birini işaretleyiniz.					
	Çocukluğumda ya da ergenliğimde…					
1	Yeterli yemeğim olurdu.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
2	Gündelik bakım ve güvenliğim sağlanıyordu.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
3	Anne ya da babam kendilerine layık olmadığımı ifade ederlerdi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
4	Fiziksel ihtiyaçlarım tam olarak karşılanırdı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
5	Ailemde sorunlarımı paylaşabileceğim biri vardı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
6	Üst baş açısından bakımsızdım.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
7	Sevildiğimi hissediyordum.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
8	Anne ya da babam kendimden utanmama neden olurdu.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
9	Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
10	Ailemde değiştirmek istediğim şeyler vardı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
11	Ailemdekiler bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da sıyrıklar oluyordu.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
12	Kayış, sopa, kordon ya da başka sert bir cisimle vurularak cezalandırılıyordum.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık

Table B.2. (cont.)

ÇOCUKLUK ÇAĞI TRAVMALARI ÖLÇEĞİ						
	Her bir madde için aşağıdaki seçeneklerden birini işaretleyiniz.					
	Çocukluğumda ya da ergenliğimde…					
13	Anne ya da babam fikirlerimi önemserdi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
14	Ailemdekiler bana kırıcı ya da saldırganca sözler söylerlerdi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
15	Fiziksel bakımdan hırpalanmış olduğuma inanıyorum.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
16	Çocukluğum mükemmeldi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
17	Bana o kadar kötü vuruluyor ya da dövülüyordum ki öğretmen, komşu ya da bir doktorun bunu fark ettiği oluyordu.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
18	Ailemde birisi benden nefret ederdi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
19	Ailemdekiler kendilerini birbirlerine yakın hissederlerdi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
20	Biri bana cinsel amaçla dokunmaya ya da kendisine dokundurtmaya çalıştı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
21	Kendisi ile cinsel ilişki kurmadığım takdirde bana zarar vermekle tehdit eden biri vardı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
22	Benim ailem dünyanın en iyisiydi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
23	Birisi beni cinsel şeyler yapmaya ya da cinsel şeylere bakmaya zorladı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık

Table B.2. (cont.)

ÇOCUKLUK ÇAĞI TRAVMALARI ÖLÇEĞİ						
	Her bir madde için aşağıdaki seçeneklerden birini işaretleyiniz.					
	Çocukluğumda ya da ergenliğimde…					
24	Birisi bana cinsel tacizde bulundu.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
25	Ailemdekiler bana karşı suçlayıcıydı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
26	İhtiyacım olduğunda beni doktora götürecek birisi vardı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
27	Cinsel istismara uğradığım kanısındayım.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
28	Ailem benim için bir güç ve destek kaynağı idi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
29	Ailemdekiler yaşıtlarımla ve arkadaşlarımla görüşmemi kısıtlardı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
30	Ailemdekiler her şeyime karışırdı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
31	Anne ve babam bir işi kendi başıma yapmama fırsat verirlerdi.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
32	Ailemdekiler rahat vermeyecek derecede peşimdeydiler.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık
33	Anne ya da babam beni kontrol etmek için kişisel eşyalarımı benden habersiz karıştırırdı.	Hiçbir zaman	Nadiren	Kimi zaman	Sık olarak	Çok sık

Table B.3. Cognitive Emotion Regulation Questionnaire (CERQ)

	BİLİŞSEL DUYGU DÜZENLEME ÖLÇEĞİ					
	Olaylarla nasıl başa çıkarsınız?					
	Herkes zaman zaman olumsuz ya da tatsız olaylarla karşılaşır ve herkes bu olaylara kendi yöntemiyle tepki verir. Lütfen aşağıdaki soruları cevaplayarak olumsuz ya da tatsız olaylar yaşadığınızda genel olarak ne düşündüğünüzü belirtiniz.					
1	Suçlanacak kişinin ben olduğumu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
2	Olanları kabul etmek zorunda olduğumu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
3	Sık sık, yaşadığım olayla ilgili ne hissettiğim hakkında düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
4	Yaşadığım şeyden daha güzel şeyler düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
5	Yapabileceğimin en iyisinin ne olduğunu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
6	Bu durumdan bir şeyler öğrenebileceğimi düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
7	"Her şey çok daha kötü olabilirdi" diye düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
8	Sık sık, yaşadığım olayın diğer insanların başına gelen olaylardan çok daha kötü olduğunu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
9	Suçlanacak kişinin başkaları olduğunu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman

Table B.3. (cont.)

	BİLİŞSEL DUYGU DÜZENLEME ÖLÇEĞİ					
	Olaylarla nasıl başa çıkarsınız?					
	Herkes zaman zaman olumsuz ya da tatsız olaylarla karşılaşır ve herkes bu olaylara kendi yöntemiyle tepki verir. Lütfen aşağıdaki soruları cevaplayarak olumsuz ya da tatsız olaylar yaşadığınızda genel olarak ne düşündüğünüzü belirtiniz.					
10	Olanlardan sorumlu olan kişinin kendim olduğunu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
11	Durumu kabul etmem gerektiğini düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
12	Zihnim yaşadığım olayla ilgili ne düşündüğüm ve ne hissettiğimle meşgul olur.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
13	Yaşadığım olayla ilgisi olmayan güzel şeyler düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
14	Bu durumla en iyi nasıl başa çıkabileceğimi düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
15	Olanların sonucunda daha güçlü bir insan olabileceğimi düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
16	Diğer insanların başından çok daha kötü şeyler geçtiğini düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
17	Yaşadığım şeyin ne kadar korkunç bir şey olduğunu düşünür dururum.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman

Table B.3. (cont.)

	BİLİŞSEL DUYGU DÜZENLEME ÖLÇEĞİ					
	Olaylarla nasıl başa çıkarsınız?					
	Herkes zaman zaman olumsuz ya da tatsız olaylarla karşılaşır ve herkes bu olaylara kendi yöntemiyle tepki verir. Lütfen aşağıdaki soruları cevaplayarak olumsuz ya da tatsız olaylar yaşadığınızda genel olarak ne düşündüğünüzü belirtiniz.					
18	Olanlardan başkalarının sorumlu olduğunu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
19	Durumla ilgili yaptığım hatalar hakkında düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
20	Durumla ilgili hiçbir şeyi değiştiremeyeceğimi düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
21	Yaşadığım olayla ilgili neden bu şekilde hissettiğimi anlamak isterim.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
22	Olanları düşünmek yerine güzel bir şey düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
23	Durumu nasıl değiştirebileceğimi düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
24	Durumun olumlu yanları da olduğunu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
25	Diğer şeylerle karşılaştırıldığında yaşadığım şeyin o kadar da kötü olmadığını düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman

Table B.3. (cont.)

	BİLİŞSEL DUYGU DÜZENLEME ÖLÇEĞİ					
	Olaylarla nasıl başa çıkarsınız?					
	Herkes zaman zaman olumsuz ya da tatsız olaylarla karşılaşır ve herkes bu olaylara kendi yöntemiyle tepki verir. Lütfen aşağıdaki soruları cevaplayarak olumsuz ya da tatsız olaylar yaşadığınızda genel olarak ne düşündüğünüzü belirtiniz.					
26	Sık sık, yaşadığım durumun bir insanın başına gelebilecek en kötü durum olduğunu düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
27	Durumla ilgili başkalarının yaptığı hataları düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
28	Temelde durum bizzat benden kaynaklanmış olmalı diye düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
29	Bu durumla yaşamayı öğrenmem gerektiğini düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
30	Durumun bende uyandırdığı duygular üzerine kafa yorarım.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
31	Yaşadığım güzel şeyler hakkında düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
32	Duruma dair yapabileceğim en iyi şeyi planlarım.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
33	Durumun olumlu yönlerini bulmaya çalışırım.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman

Table B.3. (cont.)

	BİLİŞSEL DUYGU DÜZENLEME ÖLÇEĞİ					
	Olaylarla nasıl başa çıkarsınız?					
	Herkes zaman zaman olumsuz ya da tatsız olaylarla karşılaşır ve herkes bu olaylara kendi yöntemiyle tepki verir. Lütfen aşağıdaki soruları cevaplayarak olumsuz ya da tatsız olaylar yaşadığınızda genel olarak ne düşündüğünüzü belirtiniz.					
34	Kendime hayatta bundan daha kötü şeylerin olduğunu söylerim.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
35	Sürekli bu durumun ne kadar berbat olduğunu düşünür dururum.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman
36	Sorunun temelinde diğer insanların yattığını düşünürüm.	(Neredeyse) Hiçbir zaman	Nadiren	Bazen	Sık sık	(Neredeyse) Her zaman

Table B.4. Eating Disorders Examination Questionnaire (EDE-Q-13)

	YEME BOZUKLUĞU DEĞERLENDİRME ÖLÇEĞİ							
	Aşağıdaki sorular sadece son dört hafta (28 gün) ile ilgilidir. Lütfen her soruyu dikkatlice okuyunuz. **Aşağıdaki ifadeleri son 28 günün kaç gününde deneyimlediyseniz o kadar gün sayısını işaretleyiniz.** Lütfen tüm soruları yanıtlayınız ve her soru için bir yanıt seçiniz.							
	Son 28 günün kaç gününde…	**0**	**1-5**	**6-12**	**13-15**	**16-22**	**23-27**	**Hergün**
1	bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için yediğiniz yiyecek miktarını kasıtlı olarak sınırlandırmaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)							
2	bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için sevdiğiniz herhangi bir yiyeceği beslenme düzeninizden çıkarmaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)							
3	bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için yemenizle ilgili belirli kurallara (örneğin, kalori sınırlandırması) uymaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)							
4	vücut ağırlığınız, kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi?							
5	bedeninizin şekli, kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi?							

Table B.4. (cont.)

	YEME BOZUKLUĞU DEĞERLENDİRME ÖLÇEĞİ							
	Aşağıdaki sorular sadece son dört hafta (28 gün) ile ilgilidir. Lütfen her soruyu dikkatlice okuyunuz. **Aşağıdaki ifadeleri son 28 günün kaç gününde deneyimlediyseniz o kadar gün sayısını işaretleyiniz.** Lütfen tüm soruları yanıtlayınız ve her soru için bir yanıt seçiniz.							
	Son 28 günün kaç gününde…	**0**	**1-5**	**6-12**	**13-15**	**16-22**	**23-27**	**Hergün**
6	vücut ağırlığınızdan memnun değildiniz?							
7	bedeninizin şeklinden memnun değildiniz?							
8	başka insanların alışılmadık miktarda fazla olarak tanımladıkları kadar (şartlara göre) yemek yediniz?							
9	yemek yemenizle ilgili kontrolü kaybetme hissine kapıldınız (yemek yediğiniz sırada)?							
10	aşırı yeme atakları yaşadınız (örn. alışılmadık miktarda fazla yemek yediniz ve o sırada kontrolü kaybettiğinizi hissettiniz)?							
11	bedenizin şeklini veya vücut ağırlığınızı kontrol etmek için kendinizi kusturdunuz?							
12	bedenizin şeklini veya vücut ağırlığınızı kontrol etmek için müshil (bağırsak çalıştırıcı) kullandınız?							

Table B.4. (cont.)

	YEME BOZUKLUĞU DEĞERLENDİRME ÖLÇEĞİ							
	Aşağıdaki sorular sadece son dört hafta (28 gün) ile ilgilidir. Lütfen her soruyu dikkatlice okuyunuz. **Aşağıdaki ifadeleri son 28 günün kaç gününde deneyimlediyseniz o kadar gün sayısını işaretleyiniz.** Lütfen tüm soruları yanıtlayınız ve her soru için bir yanıt seçiniz.							
	Son 28 günün kaç gününde…	**0**	**1-5**	**6-12**	**13-15**	**16-22**	**23-27**	**Hergün**
13	vücut ağırlığınızı, bedeninizin şeklini veya vücut yağ miktarınızı kontrol etmek veya kalori yakmak amacıyla "takıntılı" ya da "zorlayıcı" biçimde egzersiz yaptınız?							

APPENDIX C

ETHICAL COMMITTEE DECISION

T.C.
İBN HALDUN ÜNİVERSİTESİ
Sosyal ve Beşeri Bilimler Bilimsel Araştırma ve Yayın Etiği
Kurulu Başkanlığı

Sayı : E-71395021-050.04-39018 26.03.2024
Konu : Etik Kurulu Kararı - Ayşe ÖZÇİÇEK

İLGİLİ MAKAMA

Kurulumuza başvuran Ayşe ÖZÇİÇEK'in, "Adverse Childhood Experiences and Eating Disorder Symptomatology: The Role of Cognitive Emotion Regulation Strategies" isimli projesi; amaç, araştırma türü, veri toplama araçları, süreç ve işlemler, veri analizleri dikkate alınmak suretiyle 15.03.2024 tarihinde değerlendirilerek 2024/03-10 karar numarası ile etik açıdan uygun bulunmaktadır.

Bilgilerini ve gereğini arz/rica ederim.

Prof. Dr. Alev ERKİLET
Başkan

CURRICULUM VITAE

Full Name:
Ayşe Özçiçek Nazır

Contact Information:
E-mail:

Education:

2022 – 2025	M.A. in Counseling Psychology, İbn Haldun University, ABD
2021 – 2022	Scientific Preparation for Counseling Psychology, İbn Haldun University, Turkiye
2014 – 2019	B.A. in Turkish Language and Literature, Boğaziçi University, Turkiye

Work Experience:

2023 – 2024	Part-Time Employee, Art, Culture, and Sport Department, Ibn Haldun University, Istanbul
2019 – 2021	Translator, Repar Tasarım Matbaa ve Reklamcılık Tic. Ltd. Şti., Kitapyurdu Yayıncılık ve İletişim A.Ş., Üsküdar, İstanbul.
2019 – 2020	Lecturer, Turkish and Foreign Languages Application and Research Center (TÖMER), İbn Haldun University, İstanbul.
2028 – 2019	TA, Turkish Language and Culture Program (TLCP, Department of Linguistics, Boğaziçi University, İstanbul.

Publications:

1. Özçiçek, A. (2023). International students' adjustment challenges. *Journal of International Students, 13*(3), 537–541 www.ojed.org/index.php/jis/article/view/6442

2. Nazir, T., & Özçiçek, A. (2023). Adjustment challenges and coping strategies of Arab female international university students. *Frontiers in Psychology, 14*:125368. doi: 10.3389/fpsyg.2023.1125368

3. Nazir, T., & Özçiçek, A. (2023). Understanding the impact of the COVID-19 pandemic on the career choices of individuals by using career sailboat model. *Frontiers in Education,* 7, p. 1017). doi: 10.3389/feduc.2022.1036971

4. Nazir, T., & Özçiçek, A. (2022). Gaslighting: İki yüzlü bir duygusal istismarla yüzleşmek (Gaslighting: Confronting hypocritical kind of emotional abuse). *Anadolu Üniversitesi Eğitim Fakültesi Dergisi, 6*(3), 241-250. doi: 10.34056/aujef.1015105

5. Nazir, T., & Özçiçek, A. (2022). Language barrier, language related issues and stress among international students in Turkish universities. *International Journal of Advanced Multidisciplinary Research and Studies, 2*(2), 213–218. www.multiresearchjournal.com/arclist/list-2022.2.2/id-149

Translated Books:

1. Nazir, T. (2023). *Uluslararası öğrenciler ve uyum süreçleri*. (Trans. Özçiçek, A.). İstanbul: Nobel Yayıncılık.

2. Seneca, L. A. (2022). *Mutlu yaşam üzerine & Yaşamın kısalığı üzerine*. (Trans. Ateş, M., Özçiçek, A., & Ertaş, F.). İstanbul: Kapra Yayıncılık.

National and International Conferances:

1. Özçiçek A. & Eruyar Ş. (2024, October 04-06). *Exploring the Relationship between Childhood Maltreatment, Cognitive Emotion Regulation Strategies, and Eating Disorders* [Oral presentation]. 4th Cognitive Behavioral Psychotherapies Congress, Ankara, Turkey.

2. Özçiçek A. (2024, June 06). *Childhood maltreatment and eating disorder symptomatology: The role of cognitive emotion regulation strategies* [Oral presentation]. 7. IHU GradCon Graduate Conference, Istanbul, Turkey.

3. Özçiçek A. (2023, November 17-19). *Enneagram personality types and their predictive role in barriers to seeking mental health counseling* [Oral presentation]. *2*4th International Psychological Counseling and Guidance Congress. Ankara University, Ankara, Turkey.

4. Özçiçek A. (2022, May 20-22). *A study of the adjustment issues and coping strategies of Arab female university students in Istanbul* [Oral presentation]. 1st IHU Sociology Days: Student Research Symposium. Ibn Haldun University, Istanbul, Turkey.

5. Nazir, T. & Özçiçek, A. (2022, May 19-20). *To study the determinants of Adjustment challenges and coping strategies of international students in Turkey* [Oral presentation]. 7th International Congress on Innovative Scientific Approaches. Samsun, Turkey.

6. Nazir, T. & Özçiçek, A. (2022, February 05). *Understanding the impact of the COVID-19 pandemic on the career course of individuals by Using Career Sailboat Model* [Oral presentation]. Asian School of Business International Conference ASBIC 2022. Noida, India.

7. Özçiçek, A. & Gökgöz, K. (2018, June 18-20). *Grammatical and iconic constraints on serial verb constructions in TİD* [Poster Presentation]. Formal and Experimental Advances in Sign Language Theory (FEAST7). Ca' Foscari University, Venice, Italy.

Research Experience:

2022 – 2025	Researcher, İbn Haldun University, Istanbul. BAP (Scientific Research Grant) no.:2232, Childhood Maltreatment and Eating Disorders Symptomatology: The Role of Cognitive Emotion Regulation Strategies Project Coordinator: Dr. Şeyda Eruyar
2022 – 2024	Research Assistant, İbn Haldun University, Istanbul. BAP no.:2217, Pre And Post Arrival Adjustment Issues and Support Program For International Students Project Coordinator: Dr. Thseen Nazir.
2023 – 2024	Research Assistant, İbn Haldun University, Istanbul. BAP no.: 2214, Developing a Center of Research Methods and Statistics Project Coordinator: Prof Dr Üzeyir Ok.
2021 – 2022	Research Assistant, İbn Haldun University, Istanbul. BAP no.:1905, Adjustment Issues of International Students in Turkey Project Coordinator: Dr. Thseen Nazir.
2017 – 2018	Research Assistant, Boğaziçi University, Istanbul. Turkish Sign Language Laboratory field study and data collection Coordinator Professor: Kadir Gökgöz
June – August 2017	Research Assistant, Boğaziçi University, Istanbul. Coding Sign Language Phonetics in Turkish Sign Language Laboratory Coordinator Professor: Kadir Gökgöz

Certificates:

July *2019*	High Honor Certificate, Boğaziçi University, İstanbul. A certificate is given to students with GPAs over 3.50.
2018 – 2019	Pedagogical Formation Certificate, İstanbul University, İstanbul. The certificate is given to those who successfully complete education-related courses and are entitled to teach in schools.