EARLY MALADAPTIVE SCHEMAS, TIME PERSPECTIVE AND EATING ATTITUDE: THE MEDIATING ROLE OF EMOTION REGULATION AND EMOTION REACTIVITY

CEYDA TUNCA DEMİRBAŞ

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Name Surname: Ceyda Tunca Demirbaş
Signature:

ABSTRACT

EARLY MALADAPTIVE SCHEMAS, TIME PERSPECTIVE AND EATING ATTITUDE: THE MEDIATING ROLE OF EMOTION REGULATION AND EMOTION REACTIVITY

Demirbaş Tunca, Ceyda

M.A., Clinical Psychology

Supervisor: Assistant Prof. B. Türküler Aka

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This current study examined whether emotion regulation and emotional reactivity mediated the relationship between time perspective, early maladaptive schemas and eating attitude. For this purpose, 258 (74 male, 183 female, 1 other) participants between the ages of 18 and 35 (M= 26.18) were attended in the study. In order to assess individuals' time perspective, Time Perspective Scale was used. In order to evaluate early maladaptive schemas, Young Schemas Questionnaire- Short Form-3 (YSQ-SF3) was used. Individual's eating attitude were evaluated with The Eating Attitude Test-40 (EAT-40). Individual's coping strategies with felling and emotional

expressions were measured with The Emotion Regulation Scale. And, individuals' reactivity affect against interpersonal relationships were assessed with The Emotional Reactivity Scale. In the study, the two mediation analysis was conducted by using bootstrapped multivariate extension of the INDIRECT test of mediation, which evaluates the total, direct and indirect effects of independent variable (i.e., Early Maladaptive Schemas and Time Perspective) on dependent variable (Eating Attitude) through a stated mediator (i.e., Emotion Regulation and Emotional Reactivity). According to first mediation analysis result, past negative and present fatalistic had direct effect on eating attitude, however, there is no found indirect effect between time perspective and eating attitude through emotional regulation and emotional reactivity. According to second mediation analysis results, other-directedness had direct effect on eating attitude. Moreover, impaired autonomy and disconnection had indirect effect on eating attitude through psychological durability. In the light of eating attitude literature, the findings, limitations and suggestion for future research were discussed.

Key Words: Early maladaptive schemas, time perspective, emotion regulation, emotional reactivity, eating attitude

ÖZ

ERKEN DÖNEM UYUMSUZ ŞEMALARI,
ZAMAN ALGISI VE YEME TUTUMLARI: DUYGU DÜZENLEME VE
DUYGUSAL TEPKİSELLİĞİN ARACI ROLE İLİŞKİN ANALİZİ

Demirbaş Tunca, Ceyda

Yüksek Lisans, Klinik Psikoloji
Tez Yöneticisi: Yrd. Doç. Dr. B. Türküler Aka

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Bu çalışmada, duygu düzenleme ve duygusal tepkiselliğin, zaman algısı, erken dönem uyumsuz şemaları ve yeme tutumları üzerindeki aracı etkisi incelemektedir. Buradan yola çıkarak, yaşları 18 ile 36 yaş (M=26.18) olan 258 kişi (74 erkek, 183 kadın, 1 diğer) çalışmaya katılmıştır. Bireylerin zaman algılarını ölçmek için Zaman Algısı Ölçeği kullanılmıştır. Kişilerin erken dönem uyumsuz şemalarını ölçmek için Young Şema Ölçeği Kısa form-3 kullanılmıştır. Kişilerin yeme tutumları ise Yeme Tutum Testi (YTT-40) ile ölçülmüştür. Bireylerin duyguları ve hisleriyle başa çıkma stratejileri ise Duygu Düzenleme Ölçeği ile ölçülmüştür. Son olarak, bireylerin kişiler arası ilişkilerine karşı duygusal tepkisellikleri Duygusal Tepkisellik Ölçeği ile ölçülmüştür. Bu çalışmada, 2 farklı

aracılık analizi kullanılmıştır. Analizleri yaparken total, direk ve direk olmayan etkileri bağımsız değişkenlerin (zaman algısı, ergen dönem şemalar), bağımlı değişken (yeme tutumu) üzerindeki rolüne, aracı değişkenleri (duygu düzenleme ve duygusal tepkisellik) kullanarak bakılmıştır. Çalışmanın sonuçlarına göre, birinci analizde geçmişi olumsuz değerlendirme ve şimdide kaderciliği ile yeme tutumu arasında direk etki bulunmuştur fakat duygu düzenleme ve duygusal tepkiselliğin, zaman algısı ve yeme tutumu arasındaki direkt olmayan ilişkiye aracılık ettiği görülmemiştir. İkinci analizde ise, diğeri yönelimlilik şema alanının yeme tutumu ile arasında direk etki bulunmuştur. Son olarak, zedelenmiş ve kopukluk şema alanları ile yeme tutumu arasındaki direkt olmayan ilişkiye psikolojik dayanıklılığın aracılık ettiği görülmüştür. Son olarak, araştırmanın bulguları yeme tutumu literatürü kapsamında değerlendirilmiş, çalışmanın kısıtlılıkları ve gelecek çalışmalar için önerileri tartışılmıştır.

Anahtar kelimeler: Erken dönem uyumsuz şemaları, zaman algısı, duygu düzenleme, duygusal tepkisellik, yeme tutumu

To my amazing husband

Ozan Demirbas

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CHAPTER 1

INTRODUCTION

1.1. Eating Disorders and Eating Attitudes

From the late 1960's, the concept of body image, physical appearance, body shape, eating habits, and eating behavior problems have begun to take important place in our lives. People's eating attitudes have evolved in time and irregular working hours, and timelessness has begun to be used as excuses for adapting fast food style. Particularly, mass media and advertisement have fostered the maladaptive eating styles. The changes on eating attitude have brought issues related with eating disorders. Although, nourishment has physiological aspects and needs, its psychological aspects have caused much more debates in literature. Eating attitude is discussed from various aspects.

First of all, in order to gain understanding about eating attitudes, the meaning of attitude needs to be explained. The concept of attitude in psychology refers to individual's imputed thoughts, emotions and behaviors which are formed with

reference to individuals' predispositions (Smith, 1968 as cited in Arkonaç, 2008). From this perspective, eating attitude is briefly conceptualized as individuals' predisposition about eating as a result of individuals' thoughts about eating and nourishment, behaviors and emotions. Normal and abnormal behaviors associate with eating, which occur as a consequence of individuals' tendency. Adolescence period and rapid change on body, increasing interest on body shape, having ideals about being thin and muscled may direct to this tendency. Body image would carry too much importance in this period, therefore abnormal eating attitude and behaviors may establish a ground for Anorexia Nervosa and Bulimia Nervosa (Aytin, 2014). In order to gain understanding about eating disorders, the process that leads to the development of eating disorders should be well established. Calam and Waller (1998) highlight that disordered eating attitudes and behaviors would demonstrate a continuation in time, and may trigger the emergence of the disorder in future. The relationship between disordered eating attitudes and development of eating pathology is seen remarkable therefore, the continuum hypothesis is suggested about eating pathology. The continuum hypothesis is presented first by Nylander, and then is developed by Rodin et al. (as cited in Scarano & Kalodner-Martin,1994).The continuum hypothesis helps to form a frame in order to gain insight for similarities and differences between problematic eating attitudes and eating disorder (Aytin, 2014). According to continuum hypothesis, individuals are diagnosed with different sub-groups of eating disorders, demonstrate differentiation on the degree of their eating behaviors; but psychological similarities are also observed to a certain extent which take place on the same continuum (Aytin, 2014). In other words, groups only differentiate each other according to the intensity and frequency of their problems (Scarano & Kaloner-Martin, 1994). Perosa and Perosa, (2004) presented a model that begins with 'normal' eating

pattern, and bulimia takes its place at the end of the line and sub-clinical groups take their place in the middle of the continuum (see in Figure 1.).

Normal	Worrying about weight	Chronic dieters	Binge eaters	Sub-threshold bulimia	Bulimia

Figure 1. Continuum Eating Model

As it can be seen, anorexia nervosa is not located on the continuum. Afterwards, for this purpose, Williamson et al. (2002) asserted that anorexia nervosa could not be evaluated as types of eating disorder, therefore it could be evaluated as severity of symptoms on continuum (as cited in Perosa & Perosa, 2004). This continuum demonstrates that different eating problems may turn into different eating disorders as time progresses (Pike & Rodin, 1991; Stice et al., 1988 as cited in Çakırlı-Alşan, 2005). In the light of such information, eating disorders should not be restricted with anorexia and bulimia, eating attitude and behaviors should be taken into consideration in order to investigate the path that causes to eating disorders. Besides, the underlying factors are lead to sustain to be in the continuum need to be examined before individuals develop eating disorder symptomology. In the following part, eating disorders and sub-groups were discussed.

1.2. Introduction to Eating Disorders

The occurrence of eating disorders might be based on genetic factors, family structure, psychological, and sociocultural factors (Maner & Aydın, 2007). Particularly, several physical symptoms are observed as mutually present on Eating Disorders, so that the recovery rate is low, and also relapse rate is high (Lindberg & Hjern, 2003). It is difficult to base the underlying mechanisms of eating disorders on

simple factors. These mechanisms are multifactorial and the interactions among various individual and environmental factors predispose, sustain and set the stage for eating disorders.

Healthy individuals define themselves according to their relationships, their parenting skills, their jobs, their sports activities and self-evaluations based on their perception of performance; whereas, people with eating disorder extravagantly determine their self-worth according to their body weights-shapes and the control that they have on their body weights-shapes (Fairburn & Harrison, 2003).

Eating disorders are clustered in five main categories; which are Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Avoidant/restrictive Food Intake Disorder (ARFID), Other Specified Feeding or Eating Disorder and Unspecified Feeding or Eating Disorder. In addition, currently Binge Eating Disorder is clustered as a separate diagnosis category for the first time (APA, 2013).

At the very beginning, Anorexia Nervosa was defined as an eating disorder category. It is defined as a clinic pathology in 1873 by Lasegue on the article named‘‘De l’Anorexia Hysterique’’. Bruch (1994), defined three psychological symptoms on Anorexia Nervosa patients as distortions on body image, inappropriate interpretations and perceptions of bodily sensations, and feelings and thoughts of inadequacy on various situations. Feelings of inadequacy is accepted as the core pathology of Anorexia Nervosa. The significant components of Anorexia Nervosa is having intensely annoying feelings related to weight gain and becoming fat, significant disturbances on perceptions about the shape or size of the body, rejection of the body weight though it is below normal standards (APA, 2013). Anorexia Nervosa is consisted of two sub-types; restricting type and binge eating/purging type. The most

important point for restricting type is that individual severely restricts their food intake. Restriction show up in various form (e.g. counting calories; restriction of food intake; eating only one meal a day) and some rigid and obsessive rules may occur (e.g. only eating food of unique color). For the binge eating/purging type, individual also restrict their food intake as restriction type however binge-eating or purging behavior may accompanied (e.g. self-purging behavior, over-exercise, misuse of laxatives, diuretics or enemas) (APA, 2013). Losing weight is comprehended as a kind of achievement, and a sign of self-control and discipline for anorexic patients (PDM, 2006; Smith, 2008).

Bulimia Nervosa is another types of eating disorder that refers to recurrent episodes of binge eating. Using inappropriate compensating methods in order to avoid binge eating and gaining weight. Individual eats huge amount of food in specific times unlike other people who are in the similar condition (APA, 2013).

Binge Eating Disorder is newly added as a types of eating disorder that refers to repetitive episodes of eating. Individual significantly eat huge amount of food in specific time rather than other people who are in under similar condition. The most remarkable point of this episode is feelings of lack of control. Binge eaters might eat too quickly, even though they are not hunger. Feelings of guilt, embarrassment or disgust might be holed and in order to escape from these feelings, they might binge eat alone (APA, 2013).

Avoidant/Restrictive Food Intake Disorder (AFFID) is new types of eating disorders that refers to significant loss of weight, having dependency for enteral feeding or oral nutritional, marking interference with psychosocial functioning supplements are observed (APA, 2013). Other Specified Feeding or Eating Disorder

and Unspecified Feeding or Eating Disorder (OSFED) is also new diagnostic criteria. If individuals' eating and feeding behaviors lead to clinically significant distress and impaired functioning in some areas however, do not meet full of criteria with regard to other feeding and eating disorders are diagnosed with OSFED (APA, 2013).

Anorexia nervosa begins in middle-late adolescents' period (14-18 age). (APA, 2013). It is rarely seen before initial menstruation period. On the other hand, the beginning of bulimia nervosa mostly seen in late adolescent or adult period (APA, 2013). In other words, the beginning of bulimia nervosa is later than anorexia nervosa (Kocabaşoğlu, 2001). Generally, the onset of the disorder is associated with stressful life events (O'Dea, 2002). The course and results of disorders demonstrate diversity among patients (APA, 2013). However period of disorder takes approximately 18 months (Eating disorder in adult women, 2012).The death rate varies from 0% to 22%, though the highest mortality rate among psychiatric disorders (app. 5.6%) is seen on anorexia nervosa patients. Anorexia nervosa is a treatable disorder however, damage on limbs leads to increased death rate (Eating disorder in adult women, 2012). According to universal Eating Disorders researches demonstrates that western culture is highly risky group rather than other cultures (Fairburn and Harrioson, 2003). On the other hand, eating problems also begins to significant issue for eastern culture (Latzar, Azaiza and Tzischinsky, 2009; Nobakht and Dezhkam, 2000 as cited in Vardar and Erzengin, 2011).

In general point of research, eating disorder studies merely focus on adolescents and university students (Baş and et al., 2004; Edman and Yates, 2004; Kırk, Sing and Getz, 2001; Nelson and ark, 1999), Turkey follows similar pathway as well; most of the research aim to investigate eating pathology focused on adolescents

and university students (Altuğ, Elal, Slade & Tekcan, 2000; Canpolat, Örsel, Akdemir & Özhay, 2005; Erol, Toprak & Yazıcı, 2006; Kuğu et al., 2006). The population is selected according to their availability and prevalence rates of the disorder among the group (O'Dea, 2002). The most prevalent age for anorexia nervosa is between 15-19 ages, whereas the most prevalent age for bulimia is between 14-20 ages (Hoek & Hoeken, 2003). Higher prevalence rates between the ages of 14-20 are related with the fulfillment of self-actualization needs through body appearance (Ertaş, 2006). Correspondingly, in this period dieting activity makes people more vulnerable and more interested in their body appearance (Hausenblas & Mack, 1999).

According to DSM-V criteria, lifetime prevalence by age 20 of eating disorder was found 0.8% for anorexia nervosa, 2.6% for bulimia nervosa, 3.0% for binge eating, 2.8% for anorexia, 4.4% for sub-clinical bulimia, 3.6% for sub-clinic binge eating, and 3.4% for purging (Stice, Marti & Rohde, 2013).

In general, prevalence studies in Turkey is based on population-based screening, and the studies frequently are conducted on the risky group for eating disorder (High school students, college students sample) (Kuğu, Akyüz, Doğan, Ersan & İzgiç, 2002; Tozun, Unsal, Ayrancı & Arslan, 2010; Vardar & Erzengin, 2011). In Turkey, general population-based screening studies merely was conducted by Semiz, Kavakçı, Yağız, Yonter and Kuğu (2013). Sivas sample was used and prevalence of eating disorder was found 1.52%, 0% for anorexia nervosa, 0.63% for bulimia nervosa, and 0.81% for binge eating disorder (Semiz, Kavakçı, Yağız, Yonter and Kuğu, 2013). Findings demonstrate that binge eating disorder is seen as the most common type. According to Vardar and Erzengin (2011) studies demonstrate that adolescents' prevalence for both gender was found 2.33%. Prevalence of anorexia nervosa 0.034%

(1 person) for women whereas, prevalence of bulimia nervosa was found 0.79% (23 person) for women. The findings of the study presented that the most prevalent eating disorder type was found as atypic eating disorder, 2.39% for women, and 0.62% for men.

According to findings of Turkey, prevalence of anorexia nervosa is lower than western countries however, prevalence of other eating disorder types demonstrate similarities. The point prevalence rate for Eating Disorders among all the participants was 2.3% whereas it was found 4.03% for female participants (Vardar and Erzengin, 2011). Treasure (2004), prevalence studies demonstrate that 5-10% of young women have at least one type of eating disorder. The findings indicate similarities between Turkey population-based screening studies.

Attitude studies on eating disorder symptoms have begun to spread particularly on university students in order to investigate predisposition. Individual's eating attitude can be conceptualized as taking place in the middle of the spectrum from normal eating behavior to disordered eating habit. In addition, the concept of eating attitude mostly aims to determine the path which lead to occurrence of eating disorder spectrum and detecting eating disorder and determining individuals with this pattern. Therefore, in this study, eating attitude is going to be investigated by examining this path.

1.3. Factors Related to Eating Disorders

According to the literature, eating disorders are formed by several factors that make people vulnerable for develop maladaptive eating pattern. This means that the etiology of the eating disorders consist multifarious factors. Mussell et al., (2000) indicated that composition of biological, familial, environmental, psychological, developmental and socio-cultural factors constitute the eating disorder pathology.

Etiology of eating pathology is not completely understood, however genetics, sociocultural, psychological, and parental factors have been highlighted (Kuruoğlu & Arıkan, 2000). Although, the results of the etiology studies indicate variability, all of them emphasize the importance of parental and genetic factors (Kuruoğlu & Arıkan, 2000). The importance of genetic factors is stated that binge eating behavior and purging behavior have a common gene (Ertaş, 2006). Eating attitudes of the individuals who are diagnosed with bulimia nervosa or anorexia nervosa, carry similarities with the eating attitudes of their parents (Ertaş, 2006). This highlights the importance of genetic factors on eating pathology.

One of the factors that contributes to eating disorder is socio-cultural factors. Preoccupation with weight and shape (Striegel-Moore et al., 1986), contribution of the industrial culture and emphasized beauty (Dolan, 1991; Mc Carthy, 1990; Pate, Pumariega, Hester, & Garner, 1992; Prince, 1985 as cited in Mussell et al., 2000) are the primary aspects for the social-cultural factors.

The other factor is related with eating disorder pathology is psychosocial factors. Cohen and Petrie (2005) focused on psychosocial factors such as dysfunctional cognition, negative and positive affect (mood, esteem), body attitudes (body shape,

body part satisfaction, attractiveness, and social desirability) in a study of eating pathology factors for a sample of undergraduate women. In this study, three groups were categorized (symptomatic, asymptomatic and eating disordered) and the categorization of the sample was made according to each factors' effect in terms of pathological process. The results indicate that more pathological behavior (bulimia, weight fluctuation, and dietary group), more dysfunctional cognition (approval by others, dichotomous thinking, weight and approval) and more dysfunctional body image (satisfaction with face, concern with body face) are observed in eating disordered group. After eating disordered group, symptomatic group and asymptomatic group followed respectively in terms of factors. However, there is no significant differences between disordered group and symptomatic in terms of some affective variables (sad, anxious, guilty, esteem), some cognition (catastrophizing, vulnerability) and some body factors (body satisfaction, importance of being attractive and physically fit) (Cohen & Petrie, 2005).

Another eating disorder risk factor is seen as culture (Garfinkel & Garner, 1982). Keel and Klump (2003) focused on whether anorexia nervosa and bulimia nervosa have a relationship with cultural phenomenon or not. Results shows that there is no cultural bounding syndrome with anorexia nervosa. On the other hand, anorexia nervosa patients might refuse to eat though weight gain and idealizing of thinness might not be seen as a concern. Weight concern and idealizing of thinness are only seen in Western culture values as a diagnostic criteria. On the contrary, there is cultural bounding syndrome with bulimia nervosa since, at the end of twentieth century, hugely increasing rate is monitored that it is provided in terms of the effect of Western culture.

Acculturation is another risk factors for eating disorder. Results demonstrate that acculturated individuals have higher rates of eating disorders symptoms (Davis & Katzman, 1999; Gowen, et al., 1999; Hooper & Garner, 1986; cited in Jacobi et al., 2004). Social support is accepted as another risk factor for eating disorder pathology. A research was conducted in order to assessing social support level for anorexia nervosa patients and bulimia nervosa patients (Tiller et al., 1997). The result shows that both of the patient groups had less social support figures unlike normal population. Bulimics have more tendency to getting partner rather than anorexics, while the size and adequacy of their social networks lead to more problematic issues rather than anorexics.

Gender is an essential risk factor for eating disorder. Since gender cannot be changed, it is evaluated as fixed indicator (Striegel-Moore & Cachelin, 2001). According to studies, 90-95% of patients who were diagnosed with eating disorder were women (APA, 2000). There are similarities in Turkish studies as well. In the Turkish adolescent sample, girls are diagnosed more and they are more vulnerable for eating disorder pathology (Demir et al., 1998). The reason for the differences between men and women is that women are less satisfied about their appearance rather than men (Conner et al., 2004).

Economic condition is also a related factor. Kocabaşoğlu (2001) and Ortaçgil (2001) research demonstrated that the pathology is mostly seen in members of the families with middle and high income.

Occupational factors were also revealed as eating disorder pathology risk factors. Eating disorder is mostly monitored the occupation groups such as women

dancers, ballerinas and athletes (Garner and Garfinkel, 1980; Hamilton, Brook-Gunn and Warren, 1985).

As it is seen, the combination of several factors is effective on occurrence of eating pathology. In addition to the factors which were mentioned above, emotional factors (emotional reactivity, emotional regulation), early maladaptive schemas and time perspective which are part of parental and psychological factors, were investigated as eating pathology factors.

1.3.1. Early Maladaptive Schemas

Early Maladaptive Schemas are defined as ‘‘self-defeating emotional and cognitive patterns that begin early in our development and repeat throughout life ’’ (Young, Klosko and Weishaar, 2003, p.7). In other words, negative experiences and interactions during childhood or adolescence elicit some kind of dysfunctional schemas related to unconditional, self-defeating emotional and cognitive patterns (Young, 1999). Schemas have dimensional properties; therefore schemas might demonstrate prevalence and intensity in different levels. When intensity begins to increase, the number of situations acts as a trigger for the development of schema. Besides, when intensity of schema begins to get higher, the intensity of negative feeling and the period of negative feeling begin to extend (Young, 1990; Young and et al., 2003).

Young and et al., (2003) stated that the development of early maladaptive schemas during childhood or adolescence includes several processes. Below, three reasons, which are rooted in early maladaptive schemas, are explained.

1) Fulfillment of basic emotional needs: Young presents some basic universal needs which are essential to be fulfilled during childhood period. The intensity of basic needs might vary among people. As a result, to grow as an adaptive and psychologically healthy individual, the basic needs should be met. These needs are;

    - Secure attachment to others (security, stability, care and acceptance)
    - Autonomy, competences, sense of identity
    - Expression of emotions and needs
    - Being spontaneous and game

As it was noted before, obstructiveness of early basic needs of child lead to occurrence of maladaptive schemas, and the needs meet in maladaptive ways. The interactions of environmental factors and the temperament of children are seen as underlying cause for early maladaptive schemas.

2) Early life experiences: The root of the numerous maladaptive schemas includes several traumatic childhood memories. Several theories, especially attachment theory, mentions that the representation of child by reference to family determines the child's own representation against the whole world. Therefore, the interaction with parents in earlier period of life is very essential. When early maladaptive schemas are activated, generally they are experienced as similar scenes which are based on childhood memories which were actualized within the family.

According to the model, the underlying reasons of schemas are categorized under four headings;

- Restriction of needs: When the most basic needs, such as understanding, stability and compassion, are not met, it leads to development of emotional deprivation or abandonment schemas.
- Traumatization: When childhood traumatic events, especially physically or emotionally, are suffered, the schemas such as insecurity/abuse, defectiveness/shame, lack of resistance to disease and threat occurs.
- Overprotective: The basic need of autonomy and setting bounds are disregarded. Parents may be overprotective and they can intervene excessively. On the contrary, they may avoid to set limits and demonstrate excessive amount of tolerance. Both these attitudes are not evaluated as adaptive. These situations are associated with the dependent/inadequacy, righteousness/grandiosity schemas.
- Selective internalization or identification of significant others: The child internalizes his parent's thoughts, emotions, experiences and behaviors in a selective way. For instance, children who are beaten by their parents, and who are not able to respond to this violence, may end up as 'victim' or may internalize this anger and related behavior. At this point, temperament takes an important role to determine the perspective of child.

3) Emotional Temperament: Every child has different and unique personality from birth, and its interaction with experiences in early period of life takes an important role on formation of schemas.

Young et al., (2000), present 5 schema domains and they include 18 schemas. The first group of schemas consists *abandonment, instability, mistrust-abuse,*

emotional deprivation, defectiveness-shame, social isolation, alienation under the domain of disconnection and rejection. A person who has these kind of schemas, struggles with establishing secure and satisfactory attachment with others.

The second group of schemas are dependence, *incompetence, vulnerability to harm or illness, enmeshment-undeveloped self,* and *failure* under the domain of impaired autonomy and performance. The expectation from self and world, the skills of distinguishing from parental figure and acting independently are in conflict with each other. The individual faces with struggle to establish his identity, life and he faces to struggling in establishing new personal targets in order to successfully achieving the target, and having skills for it.

The third group of schema includes *entitlement, grandiosity, insufficiency, self-control,* and *self-discipline* under the domain of impaired limits. An individual who has one or more of these schemas have problems in respecting others, collaborating to others, keeping one's word or establishing long-term targets.

The fourth group of schemas includes *subjugation, self-sacrifice, approval-seeking,* and *recognition seeking* under the domain of other directedness. An individual who have one or more of these schemas keeps his needs in the background, and takes others' needs to forefront in order to gaining acceptance, keeping emotional touch or avoiding negative evaluation.

The fifth group of schemas are *negativity/pessimism, emotional inhibition, unrelenting standards, hypercriticalness,* and *punitiveness* under the domain of over vigilance and inhibition. An individual who has one or more of these schemas suppresses his emotions and impulses. The individual avoids expressing himself, relaxation, and intimate relationships in order to reach internal standards.

Recently, several researchers have begun to study the relationship between eating patterns and Young's early maladaptive schemas (Batur, 2004; Jones, Haris and Leung, 2006; Leung, Waller and Thomas, 1999; Sines, Waller, Meyer and Wigley, 2008). Initially, early maladaptive schemas were developed in order to give explanation for dysfunctional beliefs regarding individuals with chronic anxiety, depressive disorders and personality disorder; and then schema-focused cognitive therapy was developed in order to treat these individuals (Young, 1990). Later on, individuals with other chronic diseases such as eating disorders, began to benefit from schema therapy as well (Ohanian, 2002; Waller et al., 2007).

Individuals use compensating behaviors in order to handle their schemas; therefore it is considered that distorted eating pattern might be evaluated as a sort of compensating behavior. In this way, distorted eating pattern help to escape from intolerable emotions which are activated by schemas (Sheffield, Waller, Emanelli, Muray & Meyer, 2009).

Great numbers of study present that anorexic and bulimic patients have much more particular maladaptive schemas rather than healthy control groups (Dingemans, Spinhoven & Van Furth, 2006; Leung, Waller, & Thomas, 1999) or the groups that are in recovery (Jones, Harris & Leung, 2005)

Batur, (2004) presents in a study, which examines the relationship between eating disorders and early maladaptive schemas among university students and high school students, that there are differences between eating disorder group and control group in terms of maladaptive schemas which are mistrust/abuse, vulnerability to harm and illness, unrelenting standards and insufficient self-control. Patients who were diagnosed with eating disorders and participants who reached the cut of score

demonstrate that they have more maladaptive schemas in the sense of four schemas than control group. The schemas of emotional deprivation, mistrust/abuse, dependency, and insufficient self-control vary among patients who were clinically diagnosed with eating disorder (anorexia nervosa- bulimic type, anorexia nervosa-restrained type, and bulimia nervosa), anorexia nervosa patient unlike other patients. A gender difference between male and female is also observed on early maladaptive schemas. The schemas of emotional deprivation, mistrust/abuse and insufficient self-control demonstrate differences between female eating pathology and male eating pathology (Batur, 2004).

Cooper, Rose and Turner (2005) conducted research on 272 people with an age range of 17 -18. According to eating attitude test results, participants were grouped into two as low eating attitude scores and high eating attitude scores. Moreover, individuals with depressive symptoms were excluded, and basic beliefs related to eating disorder and schemas were investigated. The group with high eating disorder scores were found to be related to schemas of abandonment, enmeshment, subjugation, emotional deprivation, and unrelenting standards. When these items are examined in detail, people who have high scores from eating attitude test present particular characteristics such as waiting for abuse, having doubts about people, having dependent relationships, having trouble for breaking off with family, fear of being abandoned, feeling being unimportant to others, thinking other people more than themselves, listening other people's problems, spending too much time and interest in others than themselves, being controlled emotionally, showing effort for unrelenting standards and for fulfilling the responsibilities, having difficulty to accept the perfect one and having needs to feel special.

Vlierberghe, Braet and Gossens (2009) conducted a research on overweight individuals between the ages of 12 to 18. Study investigated the relationship between maladaptive schemas and eating pathology. In the study, overweight individuals were grouped according to their gender, age, status, and weight level. 32 overweight young people who lose their control over eating and 32 overweight young people who do not lose their control over eating were compared in terms of their depression levels and early maladaptive schemas. According to results, people who lose their control over eating have much more dysfunctional schemas than people who do not lose their control over eating. Specifically, participants who do not lose control over eating have more multiple maladaptive schemas such as, abandonment, distrust, social isolation, failure, subjugation and unrelenting standards. The relationship among early maladaptive schemas, restrictive eating attitude, weight concern, shape concern and depressive symptoms were investigated, instead of early maladaptive schemas and weight concern, other variables demonstrate positive relationship. Restrictive eating (emotional deprivation, distrust, failure, dependence, and insufficient self-control), eating anxiety (emotional deprivation, abandonment, distrust, social isolation, defectiveness, and subjugation), shape concern (emotional deprivation, abandonment, distrust, failure) and depression was found as related to all schemas.

Waller, Ohanian, Meyer and Osman (2000) compared bulimic women and normal women. Women with bulimia have some specific schemas such as, defectiveness, insufficient self-control and failure. Besides, bulimic women's schemas demonstrate variety due to the diversity of symptoms. Schemas of emotional inhibition predicted binge eating disorder and schemas of defectiveness predicted purging behavior. Research prove that basic beliefs take more essential part than the thought about weight, shape and eating for bulimic pathology. Schemas of defectiveness

fosters intolerable feeling in order to avoid intolerable thought, so the purging behavior is used as compensatory behavior. Likewise, in order to avoid intolerable thought which was fostered by schemas of emotional inhibition, binge eating is used as compensatory behavior. Generally, eating disorder patients leave their therapy process incomplete, therefore George, Thornton, Touzy, Waller and Beumont (2004) presented motivational and schema-focused therapy for treatment of chronic eating disorder patient. Eating disorder patients have higher scores for several schemas before treatment which are unrelenting standards, punitiveness, emotional deprivation, emotional inhibition, and social isolation. According to the reevaluation of results, no change was observed in the first six months of treatment; however the motivations of the patients increased. The augmentation should not be addressed only to motivational intervention but yet, although schemas demonstrate resistance, combination of schema therapy and motivational therapy was still thought to be beneficial. The study suggested that there is no change on schemas level, however Simpson, Morrow, van Vreeswjk and Reid (2010) studies presented that schema-focused therapy helps to decrease schema level for eating disorder patients. Pilot studies were established on 8 eating disorder patient and schema therapy was applied in a group. According to the results, after therapy eating disorder severity, the severity of the schemas and anxiety level scores were decreased unlike the scores of before therapy.

1.3.2. Time Perspective

People demonstrate differences in terms of conceptualization of time. Time Perspective (TP) considers individual differences and human experiences in a broader time orientation (Zimbardo, 1999). Also TP is considered as a non-conscious process in which individuals examine their experiences by the temporal categories of past,

present, future and these processes have effects on information processing, decision making, goal setting, and they ultimately influence behavior (Griva, Tseferidi & Anagnostopoulos, 2015). Zimbardo and Boyd (1999) present five temporal factors: (1) past positive, which has association with nostalgic, and positive attitude towards the past, (2) past negative, which is related to negative aversive thought in terms of past, (3) present hedonistic, which proposes a tendency to making for present pleasure and excitement, without or with little concern for future outcome, (4) present fatalistic, which reflects fatalistic, helpless and hopeless attitude against life, and (5) future orientation, which suggests planning and endeavoring for future goals and rewards (presented in Table 1.1).

According to the literature, patients with anorexia nervosa had significantly more negative future-oriented cognitions (Godley, Tchanturia, MacLeod & Schmidt, 2001). On the other hand, patients with bulimia nervosa had significantly more negative future oriented cognitions, whereas they had significantly less positive future-oriented cognition than control group (Godley et al. 2001).

Previous research has revealed that future orientation -instead of having disposition to immediate rewards, preferring future gains-, is related to health protective behaviors such as exercise (Daugherty & Brase, 2010; Guthrie, Lessi, Ochi & Ward, 2013; Henson, Carey, Carey & Maisto, 2006) and healthy eating habits (Mahon, Yarcheski & Yarcheski, 1997). Similar to previous research, future time perspective is based on socio-emotional selectivity theory (Carstensen, 1999), which presents that perceiving future in an open-ended way should lead to handle their goals in priority which optimize their future (e.g adopting health behavior), meanwhile perceiving future in a restrict way should lead to enhance emotionally meaningful

goals (e.g, maintaining a close relationship) (Carstensen, 1999; Löckenhoff & Carstensen, 2004). Furthermore, Piko and Brassi, (2009) asserts that adolescents who have poor dietary control holds lower levels of future orientation. Griva, Tseferidi and Anagnostopoulos (2015) presented that present fatalistic and present hedonistic orientations have a significant relationship with BMI. There is an association suggesting that when past negative and present fatalistic score is higher, BMI score is also higher; while present-hedonistic score is higher, BMI score is lower.

Griva, Tseferidi and Anagnostopoulos (2015) argue that negative feelings might have associations as a natural consequence of negative view of the past or fatalistic attitude in terms of present.

As previous studies found relationships between BMI, poor dietary control, adopting health protective behavior, bulimia nervosa, anorexia nervosa and time perspective, however, studies are very few. The present study considered the possible relationship of time perspective with eating attitudes.

Table 1.1 Time Perspectives distinguished by Zimbardo and Boyd (1999)

Time perspective	Description	Sample correlation
Past – Negative (PN)	Relates to generally negative, aversive View of past, which may emerge as a result of actual experience of unpleasant or traumatic events, of a negative reconstruction of benign events, or of a mixture of both.	Depression, aggression, low emotional stability, low self- esteem, trait anxiety
Past Positive (PP)	Reflects a warm, sentimental attitude toward the past	Friendliness, high self-esteem, low anxiety
Present-Hedonistic (PH)	Relates to hedonistic, risk-taking and pleasure – oriented attitude towards life with high impulsivity and little concern for future consequences of one's actions	Novelty and sensation seeking, low impulse control
Present- Fatalistic (PF)	''reveals a belief than the future is predestined and influenced by individual action, whereas the present must be borne with resignation because human are at the whimsical mercy of ''fate'' (Zimbardo and Boyd, 1999).	Depression, low consideration for future consequences, external locus of control
Future (F)	Relates to a general future orientation, with behavior Dominated by striving for future goals and rewards	Conscientiousness, Consideration for future consequences

(Zimbardo & Boyd, 1999)

1.3.3. Emotional Factors

Emotions are a part of every life experience and they have various functions. The multidimensionality of emotions makes them hardly explained, and complex constructs.

Dodge (1991) asserted that all the information processing is thought as an emotional process due to its functions as expressing and experiencing of the activity,

and also it could be considered as an energy level due to its functions for sustaining, organizing and increasing cognitive activity. Moreover, emotions correspond to all actions of the organism that, it is effective for providing the development of empathy, interpersonal relationship, guiding of individuals' thought and behavior and mobilization of individual or motivation for individuals' change (Lemerise & Arsenio, 2000).

Several years ago, the role of emotions in eating disorders has begun to be discussed by Bruch (1962, 1978), however the argument on the characteristics of emotions in emotional eating has not been discussed sufficiently. Cooper and Shafron, (2003) argue that the essential factors which lead to maintenance and continuity of eating disorders are emotions and difficulty in coping with emotions. On the other hand, emotions have effects on cognitive processes such as memory, decision making, and the emergence of behavior; that it would be thought as important factors for mental health (Gross & Munoz, 1995). In this context, eating disorder is not only related to cognitive and behavioral processes, contrary emotional process might be more important (Overton, Selvay, Strongman & Houston, 2005)

Emotions play an essential role for all eating disorders (Fox and Power, 2009). Especially, negative emotionality was associated with eating disorder symptoms (Bekker, van de Meerendonk & Mollerus, 2004; Hogan et al., 2002; Kitsantas, Gilligen & Kamata, 2003), that particularly the emotions of anxiety, anger, shame, and guilt differs from general population (Overton et al., 2005). Besides, Burney and Irwin (2000) mention that shame and guilt was found to be related to eating context; especially shame is associated with body, indeed women with eating disorders have a

tendency to feel shame and guilt in an effort to resist to causes of maladaptive eating behavior.

Individuals demonstrate variety significantly according to quality and intensity of their emotional responding towards stimuli and situations (Davidson, 1998). Therefore, in the light of all literature, emotion regulation and emotional reactivity are evaluated as emotional factors on maladaptive eating attitude. Emotion reactivity might be evaluated as broad concept than emotion regulation. Pe et al. (2015) assert that emotion reactivity contains emotion regulation process since, individual tries to modulate their intensity of emotional response according to emotional events in order to give appropriate response. Moreover, Nock et al. (2008) highlight that emotional reactivity is overlap with temperament. On the other hand, emotional reactivity and emotion regulation might be distinguished each other, however, two types of process ongoing interplay each other which might provide to improve current understanding about pathology, and treatment of psychopathology (Carthy, Horesn, Apter, Gross, 2010). Therefore, the evaluation of both reactivity and regulation as mediator of maladaptive eating attitude were seen essential.

1.3.3.1. Emotional Reactivity

Emotional reactivity is defined as ‘‘the extent to which an individual experiences emotions in response to a wide array of stimuli (i.e. emotion sensitivity), strongly or intensely (i.e. emotion intensity), and for a prolonged period of time before returning to baseline level of arousal (i.e., emotion persistence)’’ (Nock, 2008, p.1). Particularly, the concept of emotional reactivity refers to the occurrence of several different levels of experienced emotions, intensity of emotions and reactions during interpersonal relationship (Nock, 2008).

Several research studies have presented that the development and maintenance of psychopathology could be based on emotion regulation and emotion reactivity (Davidson, 2003; Gross, 2002; Porges, Dousaard, Roosevelt & Maiti, 1994 as cited in Nock, 2008). Previous studies investigated that problems with emotion regulation process might be the underlying reasons for several psychological disorders (e.g. Cole, Michel & Teti, 1994; Gross & John, 2003; Southam-Gerow & Kendal, 2002 as cited in Nock, 2008). Particularly, problems with emotion regulation has been presented in pathologies such as eating disorders (Safer, Telch & Agras, 2001) Nevertheless, the impact of emotional reactivity on a psychiatric symptom is less known (Nock et al., 2008). Less emphasis is on increasing emotion reactivity in studies, however increasing emotional reactivity could be stemmed from individuals' tendency to emotion regulation problem (Nock et al. 2008).

One of the important reasons to investigate emotional reactivity is to understand why or how it sustains the development and maintenance of problems (Nock et al. 2008). Trying to avoid or escape from strong emotional reactivity could be the reason of extreme behavioral problems (Hayes, Wilson, Gifford, Follette & Stroshl, 1996) such as eating disorders (Garcia-Grau, Fuste, Miro, Saldana & Bados, 2002). Indeed, as a result of having effort for avoiding intense and aversive cognitive and emotional state through emotional reactivity, disorders might be developed (Nock et al. 2008). If an individual is able to regulate his emotional and behavioral reactions, the reactivity risk decreases (Nigg, 2006). When emotional reactivity increases positively; love, respect, trust, personal struggle also increase whereas, when emotional reactivity increases in negative way, it leads to serious negative circumstances such as, disappointment, fear, aggression and suicidal behaviors (Wentzel, 1998).

Emotional reactivity measures how the reactivity affects individuals' interpersonal relationships when intense emotional feelings emerge and it has 3 main reactivity process are presented; emotional sensitivity, emotional reactivity and psychological durability (Nock et al. 2008). Psychological durability refers to the fact that instead of escaping from negative situations and feeling desperate in negative circumstances; having power in effort to struggle with all negative situations (Terzi, 2008). Emotional sensitivity could be conceptualized as having lower threshold for detecting and responding to emotional stimuli therefore, individuals who have developed emotional sensitivity, show quicker and more accurate identification toward emotional stimuli (Erikson, 2011).

In literature several studies highlight the relations between difficulty in emotion regulation and psychopathology. Particularly, emotion regulation strategies are investigated however examination of emotional reactivity has not attracted the attention. Several suggested models are presented due to new understanding about nature of existed emotions and resolving scientific questions. Emotions take huge part in individuals' conscious life and individuals demonstrate differences from each other according to their emotional responses to different context and subjective experiences (Matthew, Nock, Michelle, Wedig, Holmberg, Hooley, 2008). Therefore, in the current study, mediating role of emotional reactivity on maladaptive eating attitude was investigated.

1.3.3.2. Emotional Regulation

The concept of emotion regulation is a complex construct that the best operationalization might be formed multi-dimensionally (Gratz & Roemer, 2004). Leahy, Tirch and Napolitano, (2011) address the concept of emotion regulation that

when individual encounter with intensity of emotions in an undesired level, individual would adopt rather problematic or adaptive strategies for handling the undesired situation. Emotion regulation might provide either up-regulation in intensity of emotions, down-regulation in the effect of emotions, or the continuation of emotions. Emotions emerge in moderate level and they could be kept on manageable levels, so that individuals might handle with their emotions.

Various emotional theories were based on the conception of the emotion generative process. This concept proposes that evaluation of emotions should be established first, in order to hold emotions (Gross, 2001). After emotional cues evaluated in several perspectives, they might lead to trigger several experiential, behavioral, and physiological response tendencies (Gross & John, 2003). When response tendencies manifest themselves, there could be several modulation alternatives as emotion unfolds in progress of time (Gross & John, 2003). Gross' emotion regulation model (1998, 1999, 2007) presents two main emotion regulation strategies which could be named as antecedent-focused and response-focused strategies in terms of emotion generative process. Firstly, antecedent-focus strategies indicate that primarily behavior and peripheral physiological responding have differences, shortly before fully activation of emotion response tendencies (Gross & John, 2003). Secondly, response-focused strategies indicate that when emotion is still under development, response tendencies have been formed (Gross, 2003). Under two strategies, emotion process consist of five specific emotion regulation strategies as response-focused emotion regulation strategies include response modulation and antecedent-focused emotion regulation strategy include situation selection, situation modification, attentional development, cognitive change (Gross, 2003).

According to literature, in order to detect the differences between antecedent-focused and response-focused emotion regulation strategies, two specific strategies are presented: cognitive reappraisal and expressive suppression (Gross & John, 2003). Cognitive reappraisal is a construct that include potentially emotion-eliciting situation, also it is evaluated as a form of cognitive change that provides to change with regard to emotional impact (Lazarus & Alfert, 1964), and re-evaluation in order to decrease emotional impact (Gross, 2001). Whereas; expressive suppression is an evaluation as a form of response modulation that provides to restraining for individual's ongoing emotional state (Gross, 1998).

Gross and John (2003) propose that there are differences between reappraisal and suppression strategies from the point of consequences. Shortly before emotions are fully experienced, reappraisal strategies manifest themselves. On the other hand, when suppression manifest itself; behavioral, experiential or physiological response have already been occurred. When both of the strategies are compared in terms of using cognitive resources, and suppression regarding cognitive resources, due to it facing with more difficulties in order to handle consequences of emotion-generative process moreover, although suppression is able to decrease behavioral expression of negative emotions, it restrains the occurrence of expression of positive emotions. On the other hand, reappraisal uses relatively smaller amount of cognitive resources and is able to decrease negative emotions which are triggered experientially and behaviorally.

Development and maintenance of several sorts of pathology have been occurred due to difficulties in emotion regulation that it is evaluated as transdiagnostic risk factors (Aldao et al., 2010; Hechtman et al., 2013). A recent study indicates that

eating disorders are also in these pathologies (Svaldi et al., 2012). Emergence of disordered eating pattern is considered as blocking of awareness of emotions or avoidance of feelings (Heartherton & Beumeister, 1991; Lavender & Anderson, 2010). On that account, the reasons which lead to sustaining of the disorder might be insufficient emotion regulation skills due to difficulties with emotions and difficulties in coping with experienced emotions (Aldao & Nolen-Hoeksema, 2010).

There are several arguments which try to figure out how emotion regulation process affects eating habit. Inhibited or disinhibited food intake might provide the development of eating disorder, and when lack of more adaptive emotion regulation strategies is seen, it might function in an effort to regulate emotions (Macht, 2008; Fox and Power, 2009, Haynos and Fruzezetti, 2011; Brockmeyer et al., 2012; Naumann et al., 2014; Leehr et al., 2015). This argument is supported by experimental data which suggests increased food intake which is provided through suppression of negative emotion in both healthy normal weight students and obese individuals who have with or without binge eating disorder (Evers et al., 2010; Svaldi et al., 2014). On the other hand, Tull, Gratz, Catzman, Kimbrel and Lejuez (2010) examined that emotion regulation particularly might be related to the mechanisms of reward and punishment sensitivity that it is tried to be investigated how it is increasing risk for pathology specifically in eating disorder behavior (Bijttebier, Beck, Claes & Van der Eycken, 2009). Besides, particularly development and maintenance of binge eating disorders (Hilbert, Saelens, Stein, 2007) are influenced by the fact of emotional regulation process and negative mood (Stice, 2002).

In daily life, cognitive reappraisal is the most commonly used and adaptive emotion regulation strategy (Gross & John, 2003; Richards & Gross, 2000). Using

cognitive reappraisal strategy decreases emotional impact that is often located before emotional situation occurs, and their impact decrease through adaptive strategies (Danner & et al., 2012).

Essentially, research demonstrates that negative emotions and their maladaptive emotion regulation process take an important place in order to specify providing factors for anorexia nervosa (Harrison et al., 2009; Davies et al., 2012), bulimia nervosa (Southward et al., 2013; Lavender et al., 2014) and binge eating disorder (Vanderlinden at al., 2004; Brockmeyer et al, 2014). Research revealed that the degree of maladaptive emotion regulation strategies are determined through severity of eating disorder symptomology (Forbush & Watson, 2006; Harrison et al., 2010). On the other hand, using maladaptive emotion regulation strategy such as emotional eating, increases the severity of eating disorders symptoms (Danner & et al., 2012).

Research demonstrates that in both male and female populations, there is a connection between disordered eating, body dissatisfaction and emotion regulation abilities (Lavender and Anderson, 2010; Ambwani et al., 2014; Cooper et al., 2014). Specifically, there are different relationships among gender, emotion regulation and psychopathology. Results demonstrate that women use more emotion regulation skills than men, however emotion regulation have associations with psychopathology in both men and women (Nolen-Hoeksema, 2012).

Anorexia nervosa frequently occurs in adolescence or young adulthood; individuals' illness help them with handling complex social emotional context (Schmidt & Treasure, 2006; Zucker et al., 2007), when considered from this perspective, directly manipulating the body by virtue of decreasing psychological

distress effectively , and might be maladaptive emotion regulation strategy (Harrison, Sullivan, Tchanturia & Treasure, 2010; Mervin et al., 2011).

Whiteside, Chen, Neigbors, Hunter, Co and Larimer (2007) evaluate the disordered eating pattern and emotion regulation on non-clinical sample, there is significant relationship particularly between eating problems and understanding of emotion, identifying of emotion, and using adaptive emotion regulation strategies.

On the other hand, Lavender and Anderson (2010) conducted research on male students on difficulties in emotion regulation process and investigated eating disorder and dissatisfaction of body image. Results indicated similar findings with previous research. Difficulties in acceptance of emotional reactivity predicted eating disorder as well as dissatisfaction of body image. Besides, difficulties in emotion regulation predicted body mass index.

Consequently, great number of studies support that patients who have disordered eating pattern are inadequate on emotion regulation skills. Eating disordered patients are having difficulties with understanding of internal signal, making description of emotions and acceptance of emotions, and particularly choosing right strategies. Generally, they prefer to use non-adaptive strategy (suppression) rather than adaptive one (cognitive reappraisal) (Danner, Sterheim and Evers, 2014).

Therefore, in current study, mediating role of emotion regulation eating attitudes was investigated.

1.4. Aim of the Study

The aim of this study is to investigate the possible interactions among various factors that are considered to play a role in the etiology of eating disorders.

Specifically, it is hypothesized that there will be a significant mediation effect of emotion regulation, emotion reactivity on the relationship between early maladaptive schemas and eating disorder symptoms. Moreover, it is also hypothesized that there will be a significant mediation effect of emotion regulation, emotion reactivity on the relationship between time perspective and eating disorder symptoms.

CHAPTER 2

METHOD

2.1. Participants

In the present study, there were 257 (74 male, 183 female, 1 other) participants. Participants ranged in age between 18 and 36. The date were collected randomly. The mean age was 26, 18 (28.1 male, 25, 45 female, 20 other). All detailed information related to the demographic categories of the participants were demonstrated in Table 2.1.

Table 2.1 Demographic Characteristics of Sample

Variables		N	%
Gender	Male	74	71.2
	Female	183	28.4
	Other	1	.4
Age	18 to 25	133	52.3
	26 to 36	123	47.7
Living Area	Village	8	3.1
	County Town	54	21
	City	53	20.6
	Metropolis	139	54.1
	Other	3	1.2

2.2. Materials

In this study, Demographic data form (See Appendix A), Time Perspective Scale (See Appendix B), Young Schemas Questionnaire (See Appendix C), the Eating Attitude Test – 40 (See Appendix D), The Emotion Regulation Scale (See Appendix E), and Emotional Reactivity Scale (See Appendix F) were used.

2.2.1. Demographic Data Form

Demographic data form was composed of two parts. The first part included questions about variables such as age, gender, profession, marital status, etc. The second part includes questions about variables such as height and weight to get information about body-mass index, desired body-mass index, weight satisfaction, etc. (See Appendix A)

2.2.2. Time Perspective Scale

Time Perspective inventory was developed by Zimbardo and Boyd (1999). The aim of the scale is to measure how individuals' behavior connected in terms of their

past, present, future. The original version of the scale has 56 items and it has 5 temporal categories: Past Negative, Past Positive, Present Fatalistic, Present Hedonistic, and Future. In the form, 5 point Likert scale is used to rated items. The scale ranges from 1 (very untrue) to 5 (very true). Cronbach's alpha coefficient was .79 for present hedonistic, .77 for future, .80 for past positive, .74 for present fatalistic, .82 past negative. ZTPI was proved in terms of validity and reliability on index of individual differences.

Turkish version of the adaptation study was developed by Erginbilgic (2014). Turkish version was conducted on 2073 participants, consisted of 5 factors, explained variance is 33.45%, and KMO is .84. In current study, the Cronbach Alpha Coefficients was found .82 for the scale.

2.2.3. Young Schemas Questionnaire – Short Form-3 (YSQ-SF3)

In order to evaluate early maladaptive schemas, 90-item short form of the original Young Schemas questionnaire (YSQ-3) was used (Young & Brown, 2001). The original Young Schema Questionnaire consists of 205 items, 16 schemas and (Young & Brown, 1990). In this form, 6 point Likert scale is used to rated items. The scale ranges from 1 (not true at all) to 6 (this describes me perfectly). Afterwards, Young (1994) produces the short version which is consisted of 75 items. This forms measures 15 early maladaptive schemas which are entitled, incompetence, emotional deprivation, abandonment, emotion inhibition, self-sacrifice, vulnerability to harm, unrelenting standards, enmeshment, defectiveness, subjugation of needs, mistrust/abuse, entitlement, dependency, social isolation and insufficient self-control (Schimidt, Joiner, Young & Telch, 1995; Welburn, Coristine, Dagg, Pontefract & Jordan, 2002). All in all, approval-seeking, punitiveness and failure pessimisim

schemas was added and 90-itmes version was emerged (Young, 2004). The comparison of the short version and long version demonstrated that two forms has similar psychometric properties, and also it can be used both for research and in clinical areas. (Waller and et al. 2001; Stopa, Thorne, Waters and Preston, 2004).

Young Schema Questionnaire short form 3 consists of 18 different maladaptive schemas on 5 five domains: disconnection/rejection, impaired autonomy and performance, impaired limits, other-directedness and overvigilance and inhibition (Young, 2006). This scale also have 6 point Likert-type scale (*1= completely untrue of me; 2= mostly untrue of me; 3= slightly more true than untrue; 4=moderately true of me; 5= mostly true of me; 6= describes me perfectly*). Presence of schemas is demonstrated with higher scores on items (Young, 2006). Recent short version Turkish adaptation of the scale was developed from Karosmanoğlu, Soygüt, Derinöz, Yeroham and Tuncer (2005). The values of reliability and validity demonstrated acceptable results. According to the study, it has 15 different schemas on 5 domains. The first domain is impaired autonomy, their schemas are enmeshment, dependence, abandonment, failure pessimism and vulnerability to harm. The second domain is disconnection, their schemas are emotional deprivation, emotional inhibition, social isolation and mistrust, and defectiveness. The third domain is unrelenting standards, their schemas are unrelenting standards and subjugation. The fourth domain is other-directedness, their schema is entitlement/insufficient self-control and punitiveness. The fifth domain is impaired limits, their schemas is self-sacrifice. According to Turkish adaptation study, alpha reliabilities were .84 for Enmeshment, .87 for Abandonment, .93 for Failure, .83 for Vulnerability to harm, .89 for Emotional deprivation, .86 for Emotional inhibition, .83 for Social isolation, .88 for Defectiveness, .83 for Unrelenting standards, .79 for Entitlement, .84 for Self-

sacrifice, .83 for Mistrust, .85 for Subjugation, .75 for Insufficient self-control and .84 for Dependence (Karaosmanoğlu et al., 2009). In current study, the Cronbach Alpha Coefficients was found .97 for the scale.

2.2.4. Eating Attitude Test-40 (EAT-40)

The Eating Attitude Test (EAT) aims to measure behavior and attitudes that are present in Anorexia Nervosa. At the same time, the scale aims to evaluate Anorexia Nervosa cases among non-clinical groups (Garner & Garfinkel, 1980). The scale was developed as a self-report test by Garner and Garfinkel (1979).

Initially, the Turkish adaptation of the scale was completed by Doğan (1985), however the psychometric properties were not examined in this study. Then, the Turkish retranslation and psychometric properties of the test were carried out by Savaşır & Erol (1989). In this study, test re-test reliability coefficient was found as .65 and Cronbach alpha was found as .70. There are four interpretable sub-factors as anxiety for being fat, dieting behavior, social stress, and obsession for thinness. Abnormal eating attitudes and behaviors are determined by the sum of scores. The test cut off point is stated as +30 in order to determine abnormal eating attitudes and behavior. Eating Attitude test consists of 40 items. The scale includes 6- point Likert scale in which responses range from ‘always’, ‘very often’, ‘often’, ‘sometimes’, ‘rarely’, or ‘never’. In the study, items which are scored reversely as follows: questions 1, 18, 19, 23, 27, 39. The ratings (always, very often and often) were scored with ‘‘0’’ points while, non-extreme responses (never, rarely and sometimes) were scored with, 3, 2 point and 1 points respectively. The score system for the rest of questions, non-extreme responses (never, rarely and sometimes) were scored with ‘‘0’’ points while,

extreme responses (always, very often and often) were scored with 3, 2 points and 1 points respectively (Savaşır & Erol, 1989).

In current study, before cut-off score was applied, the Cronbach Alpha Coefficients was found .87 for the scale. However, when cut-off score were applied in order to distinguishing clinic population from normal population eating attitude, the Cronbach Alpha Coefficients was found .56.

2.2.5. The Emotion Regulation Scale

The Emotion Regulation Questionnaire was developed by Gross and John (2003). The aim of the scale is to measure how individuals cope with their feelings and emotional expressions in terms of emotional regulatory strategies. The scale consists of 10 items and two sub-scales as cognitive reappraisal (6 items) and suppression (4 items). The alpha coefficient was obtained as .79 and .73 for both cognitive reappraisal and suppression scales, respectively. For the both of the scales, test re-test reliability in the 3 month interval was found .69 (Gross and John, 2003). 7-point Likert Scale in which responses range from ‘‘strongly disagree’’ (1) to ‘‘strongly agree’’ (7) is used for ERQ.

The Turkish adaptation of the scale was conducted by Yurtsever (2008). The Cronbach Alpha Coefficients for two strategies were as follows: cognitive reappraisal .85 and suppression .78. Test- retest correlation results in a 4-week interval for cognitive reappraisal and suppression was found .88 and .82, respectively. In current study, the Cronbach Alpha Coefficients was found .84 for the scale.

2.2.6. Emotional Reactivity Scale.

Emotional Reactivity Scale was developed by Matthew, Nock, Wedig, Holmberg, Hooley (2008). The scale aims to measure how the reactivity affects individuals' interpersonal relationships when intense emotional feelings emerge. The original scale is consisted of 21 items and 3 sub factors as, sensitivity, emotional reactivity and psychological durability. 4 point Likert Scale in which responses range from ''completely agree '' (4) to ''completely disagree '' (1) is used for the scale.

Turkish adaptation of the scale was developed from Seçer, Halmatov and Gençdoğan, (2013. Three interpretable sub-factors were found as sensitivity (5), emotional reactivity (7), and psychological durability (5). Cronbach alpha was found as .94 for the total scale, as .88 for sensitivity, as .86 for emotional reactivity and as .81 for psychological durability. Test re-test reliability coefficient was found as .82. High score refers to high levels of sensitivity and emotional reactivity, and low levels of psychological durability. In current study, the Cronbach Alpha Coefficients was found .91 for the scale.

2.3. Procedure

Initially, a booklet which consists of demographic form and related measurement tools were prepared. Measurement tools were counterbalanced with three different order in order excluding ordering effect. Then, before completing the booklet, inform consent form was expected to sign by participants. Study approximately took 40-50 minutes to complete whole questionnaire.

CHAPTER 3

RESULTS

3.1. Data Analysis Plan

Before conducting analysis, in order to distinguishing normal population eating attitude from clinical population eating attitude, 32 and above was used as cut off score. Therefore, 39 participants were deleted. Moreover, multivariate outliers were applied and 6 cases were deleted, leaving 257 cases were left for analysis. Then, characteristics of measurement (standard deviation, means, minimum and maximum ranges) were calculated for scales and sub-scales (see in Table 3.1), and Person Correlation were calculated for scales and sub-scales (see in Table 3.2). These were; Time Perspective Scale with subscales of Past Negative, Past Positive, Present Fatalistic, Present Hedonistic, and Future; Emotion Regulation Questionnaire with subscales of cognitive reappraisal and suppression, Early Maladaptive Schemas with domains of impaired autonomy and performance, disconnection/rejection, over vigilance and inhibition, other-directedness and impaired limits; Emotional Reactivity

Scales with subscales of emotional sensitivity, emotional reactivity, psychological durability.

In order to test our hypotheses, the mediation analysis was conducted by using bootstrapped multivariate extension of the INDIRECT test of mediation for this procedure (Preacher & Hayes, 2008), which evaluates the total, direct and indirect effects of independent variable (i.e., Early Maladaptive Schemas and Time Perspective) on dependent variable (Eating Attitude) through a stated mediator (i.e., Emotion Regulation and Emotional Reactivity)

Table 3.1 Descriptive Information for Measures

Measures	N	Mean	SD	Range
TP				
Past neg.	257	2.27	.64	.8 – 4
Present hedo.	257	3.67	.50	2.42 – 5
Future	257	3.11	.41	1.58 – 4.17
Past positive	257	3.53	.70	1.50 – 5
Present fatalistic	257	2.71	.65	1 – 4.43
YSQ				
Impaired autonomy	257	56.58	22.08	30 – 152
Disconnection	257	43.79	16.8	23 – 107
Over vigilance	257	28.12	7.93	9 – 52
Other	257	33.78	9.81	11 – 61
Impaired limits	257	22.53	6.74	7 – 40
ERQ				
Reappraisal	257	24.62	6.24	6 – 42
Suppression	257	18.43	4.52	4 – 28
ERS				
Emotional sens.	257	14.78	3.32	5 – 20
Emotional reac.	257	16.51	4.13	7 – 28
Psychological dura.	257	13.07	3	5 – 20
EAT	257	13.64	6.69	2 – 32

(**TP**: Time Perspective Inventory, **Past neg**.: Past negative, **Present hedo**.: Present hedonistic, **Future**, **Past positive**, **Present fatalistic**; **YSQ**: Young Schemas Questionnaire – Short Form-3, **Impaired autonomy**: Impaired autonomy and performance, **Disconnection**= Disconnection/rejection; **Over vigilance**: Over vigilance and Inhibition; **Other**: Other directedness, **Impaired Limits; ERQ:** Emotion Regulation Scale, **Reappraisal**: Cognitive reappraisal, **Suppression, ERS:** Emotional Reactivity Scale, **Emotional sens**.: Emotional Sensitivity, **Emotional reac**.: Emotional Reactivity, **Psychological dura**.: Psychological Durability; **EAT**: Eating attitude Scale).

3.2. Correlation Analysis between Groups of Variables

In order to investigate the relationship between variable, bivariate correlations using the Pearson's r were conducted. In the fallowing paragraphs, the results of the correlation are reported (see in Table 3.2).

Table 3.2 Correlational Matrix

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. EAT	1															
2. PN	.21**	1														
3. PH	.09	.06	1													
4. FU	.09	.00	.10	1												
5. PP	-.03	-.12	.38**	.18**	1											
6. PF	-.02	.48**	.13*	-.16**	.09	1										
7. IMP	.16**	.55**	-.07	-.26**	-.13*	.39**	1									
8. DIS	.15*	.46**	-.12	-.26**	-.27**	.29**	.81**	1								
9. OVE	.14**	.30**	.04	.11	.08	.16*	.50**	.42**	1							
10. OTH	.22**	.43**	.09	.08	.05	.26**	.52**	.49**	.62**	1						
11. IML	.10	.25**	.29**	-.03	.04	.19**	.36**	.35**	.35**	.55**	1					
12. EMSE	.18**	.28**	.17**	.19**	.14*	.13*	.15*	-.02	.24	.25*	.18**	1				
13. EMRE	.11	.47**	.01	-.04	-.11	.30**	.44**	.32**	.21**	.24**	.15*	.51**	1			
14. PSDU	.17**	.40**	.09	.01	-.05	.25**	.35**	.19**	.27**	.20**	.23**	.60**	.79**	1		
15. REAP	-.03	.02	.07	.19**	.09	.07	-.10	.02	.08	.17**	.08	-.16*	-.25**	-.22**	1	
16. SUP	-.03	-.11	.08	.18**	.11	-.04	-.20**	-.07	.02	.12	.07	-.23**	-.33**	-.29**	.84**	1

**. Correlation is significant at the 0.01 level (2-tailed).

(EAT: Total Scores of Eating attitude Scale; PN: Past negative, PH: Present hedonistic, FU: Future, PP: Past positive, PF: Present fatalistic; IMP: Impaired autonomy and performance, DIS: Disconnection/rejection, OVE: Over vigilance and Inhibition, OTH: Other directedness, IML: Impaired Limit; EMSE: Emotional Sensitivity, EMRE: Emotional Reactivity, PSDU: Psychological Durability; REAP: Cognitive reappraisal, SUP: Suppression)

The relationship between EAT scores and Subscales of Time Perspective demonstrated that there is significant negative correlation with past positive (r = -, 117, $p < .05$), whereas significant positive correlation with past negative (r =, 178, $p < .01$). Furthermore, EAT scores and subscales of Emotion Regulation showed that there is significant negative correlation with cognitive reappraisal (r = -, 205, $p < .01$) and suppression (r = -, 231, $p < .01$). Significant positive correlation was found between EAT scores and Emotional Reactivity total score (r =, 301, $p < .01$). Moreover, the relationship between EAT scores and subscales of Emotional Reactivity showed that there is positive correlation with emotional sensitivity (r =, 198, $p < .01$), emotional reactivity (r =, 291, $p < .01$), psychological durability (r =, 294, $\underline{p} < .01$). EAT scores demonstrated significant positive correlation with Early Maladaptive schema domains of Impaired autonomy and performance (r =, 145, $p < .05$), and disconnection/rejection (r =, 114, $p < .05$).

The relationship between subscales of Time Perspective (Past Negative, Past Positive, Present Fatalistic, Present Hedonistic, and Future) and Early Maladaptive Schema domains (impaired autonomy and performance, disconnection/rejection, over vigilance and inhibition, other-directedness and impaired limits) demonstrated that there is positive correlation between impaired autonomy and past fatalistic (r =, 357, $p < .01$). Furthermore, there are negative correlation between disconnection/rejection and past positive (r = -, 270, $p < .01$), disconnection/rejection and future (r = -, 231, $p < .01$), disconnection/rejection and past negative (r = -, 430, $p < .01$). There is significant positive correlation between over vigilance and past negative (r =, 269, $p < .01$). There is significant positive correlation between other directedness and past negative (r =, 402, $p < .01$), and other directedness and present fatalistic (r =, 246, $p <$

.01). Besides, there is significant positive correlation between impaired limits and past negative (r =, 219, p < .01), impaired limits and present hedonistic (r =, 262, p < .01), and impaired limits and present fatalistic (r =, 155, p < .01).

3.3. Testing Mediation Effect

In the current study were investigated whether emotion regulation (cognitive reappraisal and suppression) and emotional reactivity (emotional reactivity, emotional sensitivity and psychological durability) mediated the relationship between time perspective (future, past negative, past positive, present hedonistic, present fatalistic), early maladaptive schemas (impaired autonomy and performance, disconnection/rejection, over vigilance and inhibition, other-directedness and impaired limits) and eating attitude. For this purpose, two mediation models were established by following Preacher and Hayes' (2008) mediation procedures. In the first model, time perspective was used as an independent variable, and in the second model early maladaptive schemas was used as an independent variable.

3.3.1. Mediation Model 1

In this Model, Emotional Reactivity and Emotional Regulation were tested as mediating effect of Time Perspective on Eating Attitude using bootstrapped multivariate extension of the INDIRECT test of mediation (Preacher & Hayes, 2008). Test of mediation were then conducted to examine whether any of the two subtypes of emotion regulation (cognitive reappraisal and suppression) and three subtypes of emotional reactivity (emotional sensitivity, emotional reactivity, psychological durability) explained the relationship between subtypes of Time Perspective (Past

Negative, Past Positive, Present Fatalistic, Present Hedonistic, and Future) and eating attitude (see in Table 3.3).

The direct effect of the past negative (IV) on the eating attitude (DV) was significant [β = 2.64, t (251) = 3.28, p < .001; R^2= .10]. The relationship with mediating variables demonstrated that past negative has effect on emotional sensitivity [β = 1.49, t (251) = 4.24, p < .001; R^2=.15], emotional reactivity [β = 2.65, t (251) = 6.36, p < .001; R^2=.23] and psychological durability [β = 1.67, t (251) = 5.31, p <.001; R^2=.17]. However, no significant mediation effect was found.

The direct effect of the present fatalistic (IV) on the eating attitude (DV) was significant [β = -1.49, t (251) = -1.97, p < .05; R^2=.08]. However, present fatalistic variable had no significant effect on the variables of emotion regulation and reactivity, and there was no significant mediation effect.

The direct effect of future, past positive, present hedonistic on eating attitudes was not significant. However, there was a significant effect of future time perspective on meditating variables. Results showed that future time perspective had effect on cognitive reappraisal [β= 3.12, t (251) = 3.22, p <.001; R^2=.05], suppression [β = 1.93, t (251) = 2.75, p <.01; R^2=.05], and emotional sensitivity [β = 1.31, t (251) = 2.68, p < .01; R^2=.15].

Table 3.3 Results of the Mediation of Time Perspective on Eating Attitude through, Emotion Regulation and Emotional Reactivity.

	Coefficient	SE	p	BC Bootstrap 95% CI	
				Lower	Upper
Total effect of IV's on eating attitute					
Past negative	2.88	.74	.00		
Present hedonistic	1.27	.89	.15		
Future	.94	1.02	.36		
Past positive	-.31	.65	.64		
Present fatalistic	-1.59	.74	.03		
Direct effect of IV's on eating attitude					
Past negative	2.64	.81	.00		
Present hedonistic	.99	.90	.27		
Future	.70	1.07	.52		
Past positive	-.42	.67	.53		
Present fatalistic	-1.49	.76	.05		
Indirect effect of IV's on eating attitude through cognitive reaapraisal					
Past negative	.03	.11		-.13	.24
Present hedonistic	-.02	.13		-.25	.16
Future	-.25	.42		-.99	.40
Past positive	-.02	.10		-.19	.12
Present fatalistic	-.09	.18		-.42	.15
Indirect effect of IV's on eating attitude through suppression					
Past negative	-.09	.18		-.42	.17
Present hedonistic	.04	.15		-.15	.31
Future	.20	.37		-.36	.85
Past positive	.03	.10		-.12	.21
Present fatalistic	.02	.11		-.14	.23
Indirect effect of IV's on eating attitude through emotional reactivity					
Past negative	-.47	.46		-1.24	.27
Present hedonistic	.01	.12		-.18	.22
Future	.02	.14		-.21	.26
Past positive	.07	.11		-.07	.27
Present fatalistic	-.12	.15		-.40	.07
Indirect effect of IV's on eating attitude through emotional sensivity					
Past negative	.27	.26		-.13	.72
Present hedonistic	.12	.15		-.07	.40
Future	.24	.25		-.12	.67
Past positive	.09	.11		-.05	.30
Present fatalistic	-.01	.09		-.15	.13
Indirect effect of IV's on eating attitude through psychological durability					
Past negative	.49	.41		-.14	1.20
Present hedonistic	.13	.18		-.09	.46
Future	.05	.17		-.20	.36
Past positive	-.06	.11		-.27	.09
Present fatalistic	.10	.14		-.07	.38

3.3.2. Mediation Model 2

In this Model, Emotional Reactivity and Emotional Regulation were tested as mediating effect of Early Maladaptive Schema Domains on Eating Attitude using bootstrapped multivariate extension of the INDIRECT test of mediation (Preacher & Hayes, 2008). Test of mediation were then conducted to examine whether any of the two subtypes of emotion regulation (cognitive reappraisal and suppression) explained

the relationship between domains of Early Maladaptive Schemas (impaired autonomy and performance, disconnection/rejection, over vigilance and inhibition, other-directedness and impaired limits) and eating attitude (see in Table 3.4).

The total effect of Early Maladaptive Schema Domains on Eating Attitude was found significant ($F_{5, 251} = 2.86$, $p < .01$). Furthermore, the direct effect of the other directedness (IV) on the eating attitude (DV), was significant [$\beta = .14$, $t\ (251) = 2.30$, $p < .05$; $R^2 = .09$]. The effect on mediating variables demonstrated that other directedness had a significant effect on cognitive reappraisal [$\beta = .17$, $t\ (251) = 3.16$, $p < .05$; $R^2 = .10$], suppression [$\beta = .13$, $t\ (251) = 3.29$, $p < .001$; $R^2 = .13$] and emotional sensitivity [$\beta = .06$, $t\ (251) = 2.31$, $p < .05$; $R^2 = .15$]. However, there was no mediation effect.

The effect on mediating variables demonstrated that impaired autonomy had a significant effect on cognitive reappraisal [$\beta = -.13$, $t\ (251) = -4.31$, $p < .001$; $R^2 = .10$], suppression [$\beta = -.11$, $t\ (251) = -.50$, $p < .001$; $R^2 = .13$], emotional sensitivity [$\beta = .05$, $t\ (251) = 3.26$, $p < .001$; $R^2 = .15$] and emotional reactivity [$\beta = .10$, $t\ (251) = 5.13$, $p < .001$; $R^2 = .20$]. Moreover, impaired autonomy had indirect effect on eating attitude through psychological durability [$\beta = 1.49$, $t\ (251) = 4.24$, $p < .001$, $R^2 = .47$] (see in Figure 2).

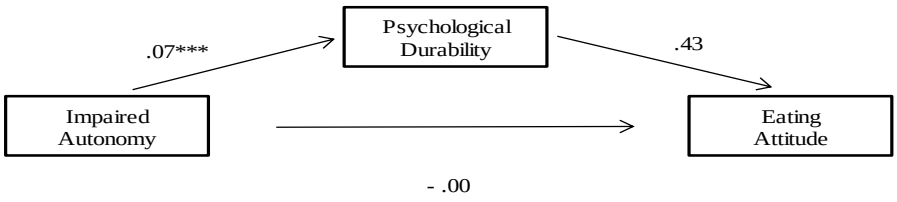

Figure 2. Mediation Model of Indirect Effect of Impaired Autonomy on Eating Attitude, through Psychological Durability.

Note: $p < .001$***

The effect on mediating variables demonstrated that disconnection/ rejection has effect on cognitive reappraisal [β = .092, t (251) = .2.42, p <.05; R^2=.10], suppression [β = .06, t (251) = 2.16, p <.05; R^2=.13], emotional sensitivity [β = -.09, t (251) = -4.58, p <.001; R^2=.15], and psychological durability [β = -.05, t (251) = -2.88, p <.001; R^2=.17]. Moreover, disconnection had indirect effect on eating attitude through psychological durability [β = 1.31, t (251) = 2.68, p <.001; R^2=.17] (see in Figure 3).

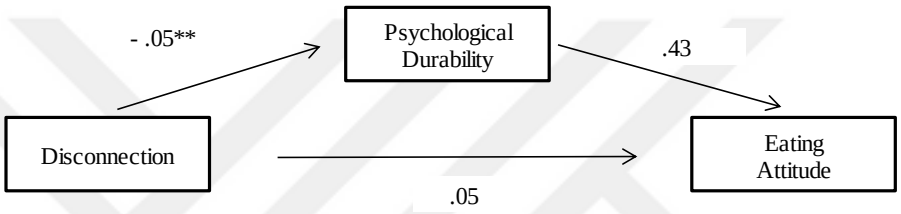

Figure 3. Mediation Model of Indirect Effect of Disconnection on Eating Attitude, through Psychological Durability.

Note: p < .01**

However, no direct effect was found for impaired autonomy and performance, disconnection/rejection, over vigilance and inhibition, and impaired limits on eating attitude.

Table 3.4 Results of the Mediation of Early Maladaptive Schemas on Eating Attitude through, Emotion Regulation and Emotional Reactivity.

	Coefficient	SE	p	BC Bootstrap 95% CI	
				Lower	Upper
Total effect of IV's on eating attitute					
Impaired autonomy	.02	1.74	.63		
Disconnection	.01	.04	.84		
Unrelenting standarts	-.01	.07	.94		
Other directedness	.14	.06	.01		
Impaired limits	-.04	.08	.59		
Direct effect of IV's on eating attitude					
Impaired autonomy	-.00	.04	.94		
Disconnection	.05	.04	.27		
Unrelenting standarts	-.03	.07	.68		
Other directedness	.14	.06	.02		
Impaired limits	-.08	.08	.33		
Indirect effect of IV's on eating attitude through cognitive reaapraisal					
Impaired autonomy	.01	.02		-.01	.04
Disconnection	-.01	.01		-.03	.01
Unrelenting standarts	-.00	.01		-.03	.01
Other directedness	-.02	.02		-.06	.02
Impaired limits	.00	.01		-.01	.02
Indirect effect of IV's on eating attitude through suppression					
Impaired autonomy	-.01	.02		-.04	.02
Disconnection	.01	.01		-.01	.03
Unrelenting standarts	.00	.01		-.01	.02
Other directedness	.01	.02		-.02	.05
Impaired limits	.00	.01		-.01	.02
Indirect effect of IV's on eating attitude through emotional reactivity					
Impaired autonomy	-.03	.02		-.06	.00
Disconnection	.01	.01		-.00	.02
Unrelenting standarts	.00	.01		-.02	.03
Other directedness	-.00	.01		-.02	.01
Impaired limits	.00	.01		-.02	.02
Indirect effect of IV's on eating attitude through emotional sensivity					
Impaired autonomy	.01	.01		-.00	.03
Disconnection	-.02	.02		-.05	.00
Unrelenting standarts	.01	.01		-.00	.04
Other directedness	.02	.01		-.00	.04
Impaired limits	.01	.01		-.01	.03
Indirect effect of IV's on eating attitude through psychological durability					
Impaired autonomy	.03	.02		.00	.06
Disconnection	-.02	.02		-.05	-.00
Unrelenting standarts	.01	.02		-.01	.05
Other directedness	-.01	.01		-.03	.01
Impaired limits	.02	.02		-.00	.06

CHAPTER 4

DISCUSSION

The main target of the current study is to investigate the associations between the early maladaptive schemas, and eating attitude, and the potential mediating role of emotion regulation and emotional reactivity in this relationship. Furthermore, the associations between time perspective and eating attitude and the potential mediating role of emotion regulation and emotional reactivity were discussed. In the light of hypothesis, the results of the study were discussed on Chapter 3 in detail.

In this part, initially the outcomes of the study will be discussed. Later, limitations of the study and suggestions for future research will be presented. Finally, the therapeutic implications of the current study will be stated.

4.1. Evaluation of the Study

The underlying mechanisms of the eating disorder are multifactorial and the interactions among various individual and environmental factors predispose and sustain eating disorders. Particularly, the recovery rate is low and also relapse rate is high (Lindberg & Hjern, 2003). Eating disorder is a significant psychiatric disorder; which may lead to serious medical complications and suicide attempts, resulting in high mortality (Agras, 2001; Fairburn & Harrison, 2003). In recent years, because of these consequences and heavy costs of eating disorders, new treatment approaches have been established, especially with the emphasis of deeper cognitive structure and emotions (Aldao & Noen-Hoeksema, 2010; Fairburn, Cooper & Shafran 2003; Leung, Waller and Thomas, 1999; Waller, Ohanian, Meyer & Osman, 2000). In addition to this, when several factors which make people vulnerable are explored; new insight about etiology of the disorder are made clear and new protective factors could be developed. Therefore, in the current study, whether emotion regulation and emotional reactivity mediated the relationship between time perspective, early maladaptive schemas, and eating attitude were all investigated. For these purposes, the risky groups of 18-36 ages were included as participants.

4.1.1. Time Perspectives and Early Maladaptive Schemas

Time perspectives and early maladaptive schemas demonstrate similar features with regard to some aspects. Time Perspective includes emotional aspects which could be affected by attachment patterns, such as secure attachment may lead to the development of past positive, present hedonistic, and future perspectives whereas, past negative time perspective is predicted by low attachment (Laghi et al., 2009).

Similarly, the occurrence of early maladaptive schemas based on whether basic needs which are fulfilled during childhood period. Particularly, secure attachment to others (security, stability, care and acceptance) are met during childhood period in maladaptive ways, lead to obstructiveness of early basic needs. In addition to this, Zimbardo and Boyd (2015) presented that time perspective has socio-cultural basis however temperamental factors which are based biologically, associated with time perspective. In similar way, early maladaptive schemas emphasize the importance of temperament. Theory of early maladaptive schemas highlight that every child has different and unique personality from birth and, its interaction with experience in early period of life is essential for formation of schemas.

In the light of the literature, time perspective and early maladaptive schemas share out similar background information, therefore two variables were evaluated as independent variables in mediation model. The mediation role of emotional reactivity and emotion regulation were investigated on time perspective, early maladaptive schemas and eating attitude.

4.1.2. Time Perspective

In the study, whether emotion regulation and emotional reactivity mediated the relationship between time perspective and eating attitude were investigated. Present fatalistic has no association with mediating variables. Moreover, the effect of past negative on mediating variables demonstrated that emotional sensitivity, emotional reactivity and psychological durability were associated. However, the results showed that past negative time perspective and present fatalistic perspective had been directly related to eating attitudes.

Zimbardo and Boyd (2015) presented that a global health behavior was conducted in order to investigate individuals' health protective and health damaging behavior such as, dieting. It was found that having more future orientation in their thinking was linked with having a predisposition for engaging in more frequent health behaviors, however it could not be known yet whether time perspective might predict unhealthy behavioral tendency such as obesity. On the other hand, in the current study it was found that past negative perspective had a direct effect on eating attitudes. Particularly, those who are more negative oriented in their thinking, disordered eating attitude could be seen more frequently. Furthermore, Zimbardo and Boyd (2015) asserted that if individual focused future time, they could most likely ignore their past and in order to control present situation, small part of cognitive resources are used. From this perspective, if individuals focusing point overly on past, they might have a tendency to ignore their future which might show that they might put at risk their health. Moreover, having healthy eating attitude might not be their concern. Therefore, past oriented individuals are far from future consequences.

Past negative oriented people has negative and aversive view of the past and they have unpleasant traumatic events that might influence on their perception of the body. Because, having too much focus on body image and having ideals about being thin might associated with past negative memory and could be related to re-experience of unpleasant trauma in a continuous pattern. On the other hand, individuals' time perspective orientation might have effect on their judgments, decisions and actions (Zimbardo and Boyd, 1999). From this perspective, past negative oriented people' judgements, decisions and actions might be influenced by their past experience. If being thin, body weights-shapes are too much emphasis in their past experience or becoming fat is reflected as terrifying issues through environmentally, parental or

socio-culturally, individuals' judgement process might lead to in appropriate interpretations on body perception in present time. Especially, parental factors might be crucial on development of maladaptive eating habit. In other words, if individual past experience consist of several parental issues; such as if parents who are perfectionistic, more rigid or overprotective or who give critical comments or who have less functional family rules, might be identifier in order to develop disordered eating attitude (Gillett et al. 2009).

In current study, disordered eating attitude was found directly associated with present fatalistic time perspective. In other words, research findings demonstrate that when individuals' present fatalistic time perspective decreases, maladaptive eating attitude increases. Present fatalistic people believe that future do not influenced by individuals' actions since, is predestined and could not be changed. Besides that they perceived lack of control over future consequences (Zimbardo and Boyd, 1999). On contrary, the importance of feeling control is hugely taken into consideration in eating pathology. When individuals' with eating disturbance or disorders feel out of control, have a tendency to control their body size. Moreover, in order to gain control, compensate behaviors are widely used. The lights of the explanations, when present fatalistic time perspective decreases, they begin to perceive more control over life. Controlling their body may provide perceiving more control over life. In other words, future consequences might be felt more predictable through having control over body. The feeling controllability might be decrease the feeling of unchangeable predestination. For instance, in order to regulate food intake and weight, crash dieting, excessive exercising, fasting or purging might be used that might help to regain body control in this way, the feeling of controllability might be strengthened through decreasing of present fatalistic time perspective. All in all, in order to regain control

of life, individual could focus easily controllability things such as, body in this way, life could be felt more controllable place and present fatalistic time perspective could demonstrate decline. Because, future might begin to influenced by individuals' actions and might not be seen as predestined place anymore.

4.1.3. Early Maladaptive Schemas

Prior research contribute to the notion that early maladaptive schemas take a part in the etiology of eating pathologies. In particular, there is evidence for anorexia and bulimic patients have much more particular maladaptive schemas rather than healthy control groups (Dingemans, Spinhoven & Van Furth, 2006; Leung, Waller, & Thomas, 1999). Moreover, the relationship was found between eating disorders and early maladaptive schemas among university students and high school students (Batur, 2004).

In the current study, the schema domain of other directedness has an effect on mediating variables of cognitive reappraisal, suppression and emotional sensitivity however, mediating effect was not found on maladaptive eating attitude. It was found that the schema domain of other directedness had a direct effect on eating attitude. The groups of schemas are entitlement, insufficient self-control and punitiveness under the domain of other directedness were found to be directly associated to eating attitudes. People who have these schemas give huge importance to other needs; other individuals' needs take precedence of individuals' own needs (Rafaeli, Berntein, & Young, 2013). Giving more importance to other needs than to own needs include some kinds of motivations, such as gaining sympathy and attention, sustaining emotional bound and feeling secure. Leung, Thomas and Waller (2000) presented that particularly anorexic people believe that they must sacrifice their own needs in order

to being accepted by others. For this purpose, literature findings and the current study findings demonstrate similarities. People who have these schemas, could have maladaptive eating attitude since; they might need to realize expectations of family, friends and society about body weight. Insufficient self-control and punitiveness could become stronger due to the expectation of getting approval.

Psychosocial factors might be essential in order to give an explanations for this direct associations. Cohen and Petrie (2005) highlight the importance of need for social desirability, approval by others, weight and approval, importance of being attractive and physically fit in order to develop for pathological eating behavior. When other-directedness schema domain was active, individual with maladaptive eating attitude might give more attention to social demands. Giving more attention to other needs than own needs might increase the motivation to internalize the psychosocial concern (e.g. need for social desirability, approval by others, importance of being attractive and physically fit).

4.1.4. The Mediating Role of Emotion Regulation and Emotional Reactivity between Time Perspectives, Early Maladaptive Schemas and Eating Attitude.

Carty et al., (2010) asserted that emotional reactivity and emotion regulation are distinguished each other however, examination of these separable process might enhance current understanding and treatment of psychopathology since, it is thought that these types has ongoing process which could be interplay together. For this purpose, in the current study, the mediating role of emotion regulation and emotional reactivity were investigated together

Whether time perspective and early maladaptive schemas have association with eating attitude through emotion regulation and emotion reactivity were investigated in the current study. Impaired autonomy, other directedness and disconnection have an effect on mediator of cognitive reappraisal and suppression. However, the mediating effect of cognitive reappraisal and suppression do not found between, early maladaptive schemas and eating attitude. However, literature supposes if people have eating problems, they become more likely to struggle with emotion regulation (Svaldi, Griepenstroh, Tuschen- Cattier & Ehring 2012; Whiteside, Chen, Neighbors, Hunter, Lo & Larimer, 2007). In order to diminish and regulate negative emotions, binge eating and disordered eating behavior are used as compensate behavior (Heartherton & Baumeister, 1991). However, current study and literature findings do not demonstrate similarities. The reasons could be originated from the degree of maladaptive emotion regulation strategies are determined through severity of eating disorder symptomology (Forbush & Watson, 2006; Harrison et al., 2010). Particularly, the concept of emotion regulation was used in an effort to give explanation for binge eating behavior and purging behavior (Fairburn, 2008; Ouwens, Strien, van Leuwe & van der Stadk, 2009). Besides, binging and purging behavior were used to escape from negative feelings (Sansone, Levitt & Sansone, 2006; Sansone & Sansone, 2010). From this perspective, current study in general perspectives only focuses on non-clinical groups' eating attitude and EAT scale tries to set sight on predisposition of anorexia nervosa. The dissimilarities between literature and current study could be explained in this way.

In current study, past negative and present fatalistic have no effect on mediators of cognitive reappraisal and suppression. A few time perspective studies focus on emotion regulation (e.g. Gross and Thompson, 2007). Present fatalistic individual have poorer emotion regulation strategies. Moreover, individuals' with past negative and

present hedonistic time orientation have disposition to low emotional competence however, do not demonstrate maladaptive trend under in all conditions (Matthewss and Stolarski,2013). Surprisingly, there is no found any associations between time perspective orientations and emotions regulations. In current study, emotion regulation was only evaluated in terms of two types of emotional regulation strategies (e.g. suppression and cognitive reappraisal). Two of emotion regulation strategies might be insufficient in order to make identification according to individuals' time perspective orientations. On the other hand, there is no relationship found between past negative and emotion regulation strategies that could be stemmed from external locus of control. Zaleski (1994) asserts that people who has future time perspective strategy able to planning for future and they generally have long term goals, are enthusiastic about achievement and have internal locus of control. People with past negative time perspective might be the exact opposite situation, therefore they might interiorize external locus of control. People who have external locus of control believe that they have no control over their fate, chance or powerful (Biondo & Macdonald, 1971). Also, there is no relationship found between present fatalistic and emotion regulation strategies. It also could be explained with similar reason. Brannigan et al. (1992) presents that people who has present fatalistic time perspective have poorer emotion regulation strategies that might be associated with external locus of control. Moreover, people who have present fatalistic and past negative time orientation have a strong tendency in order to interpret their past events in externality way (Kairys, 2010). It might lead to externalize their current problems, in this way they might believe that the underlying causes of problems are stemmed from external reasons. Therefore, in order to handle their current problems, emotion regulation strategies might not be needed.

In the current study also the mediating role of emotional reactivity (emotional reactivity, emotional sensitivity and psychological durability) was conducted between time perspective and eating attitude. Matthews & Stolarski (2013) asserts that immediate moods and general sense of well-being take from through individuals' point of view against past, present and future. For instance, having negative perspective for past determine individuals' current emotional experience (Zimbardo et al. 2012). Furthermore, increasing emotional reactivity could be stemmed from individuals' tendency to emotion regulation problem (Nock et al. 2008). Especially, negative emotionality was associated with eating disorder symptoms (Bekker, van de Meerendonk & Mollerus, 2004; Hogan et al., 2002; Kitsantas, Gilligen & Kamata, 2003). In the light of such information, possible mediation effect was expected in the current study. Although, emotional sensitivity was found associated with past negative and future, emotional reactivity was found associated with past negative and psychological durability was found associated with past negative, any mediation effect was not observed. Having intense and aversive emotional might predicts development of eating disorder symptomology through reactivity, however in current study maladaptive eating pattern were investigated on normal population. For that reason, possible mediating role could not be observed.

Overall, individual who has schema domains of impaired autonomy, other directedness, and rejection; past negative and present fatalistic time perspective demonstrate similar pattern each other. Generally, their attributions about problems and struggles are based on external events and other peoples. They avoid to make self-evaluation and give huge importance others thinking than their own thoughts. If this pattern examined in detail, individual who has impaired autonomy schema domain, always needs others help in order to handle their daily problems and they have specific

fears about Medical (hearth attack), emotional (losing control) and external (accident, natural disaster). In a similar manner, individual who has other directedness schema domain has a tendency to suppress their own needs and always needs to direct externally by others since, gaining acceptance is seen essential. Furthermore, individual who has rejection schema domains has a tendency avoid intimate relationship in order to protect themselves from external potential damage. Moreover, people who has past negative time perspective believes that their past events have control over their present and future times that influence their decisions and judgments. Similarly, present fatalistic people believe that future are not influenced by individual own action that it was controlled externally. When these similar patterns are evaluated in terms of locus of control, people who has these schema domains and time perspective, might have external locus of control. Having external locus of control disposition might lead to avoid having emotion regulation strategies. Focusing too much others thinking, avoiding self-evaluation, feeling having no control over their future and presents might cause to having external attributions about their life therefore, they might not need to emotion regulation strategies in order to cope their externally controlled events. In the light of the information, why mediation effect of emotion regulation is not found, might be explained in this way.

4.1.5. The Mediating role of Psychological Durability between Early Maladaptive Schemas and Eating Attitude.

The current study revealed that impaired autonomy has an effect on mediators of emotional sensitivity and emotional reactivity and disconnection have an effect on mediator of emotional sensitivity. However, impaired autonomy and disconnection have an indirect effect on eating attitude through psychological durability. Literature demonstrated similar findings that individuals who have disordered eating pathology, have more early maladaptive schemas than non-risky group (Jones, Leung & Harris 2006; Leung, Waller, Thomas, 1999; Waller, Ohanian, Meyer & Osman, 2003).

The groups of schemas are emotional deprivation, defectiveness-shame, emotional inhibition and social isolation under the domain of disconnection and rejection are found related to the eating attitude through psychological durability. Person who has these kinds of schemas, struggles with establishing secure and satisfactory attachment with others. The basic needs of security, stability, care, empathy and acceptance are not met, and it leads to development of these schemas (Young, Klosko & Weishaar, 2003). Having secure and satisfactory attachment is very essential in order to be resilient for negative circumstances. Doğan,(2009) highlights that if individual might take sufficient parental and environmental support, they do not feel alone and able to demonstrate more adaptive behavior to their environment that help to acquire more positive emotional and behavioral reactivity. In this way, individuals' psychological durability is quite likely increase.

On the other hand, Thomas and Waller (2000) asserted that anorexic patients have predisposition to develop a belief about themselves that they are hereditarily defective and they believe that their emotional needs are never met. Besides, research

assumed that anorexic patients developed the belief related to fact that they could not be loved and could not be cared by others in the consequences of emotional deprivation (Turner, Rose & Cooper, 2005). In the light of this information, feeling unloved and uncared might lead to trigger to feel alone and social support do not felt sufficiently. These feelings could be associated with body weight, such as, anorexic patients believe that high weight makes people unloved or if weight could be low, individuals regard themselves more acceptable. As a result these ideas could provide developing eating pathology (Cooper, Wells & Todd, 2004). Individuals who have early maladaptive schemas have some kinds of coping strategies, in order to handle with negative emotions. Cooper, Wells and Todd (2004) presented that generally individuals who have eating pathology, used dieting as compensate strategies. Dieting supports two basic ideas, firstly dieting provides individuals feel themselves more acceptable by others (e.g. if I lose weight, they could love me more). Secondly, individuals feel more acceptable (e.g. if I lose weight, it means that I am a successful person).

On the other hand, Waller et al., (2002) presented that emotional deprivations predict binge eating behavior in bulimics. From this point of view, eating behavior compensate the feeling of disconnection and rejection. Having low psychological durability might lead to choose maladaptive coping strategies. Furthermore, felling of low psychological durability could be triggered through felling low social support, having need for social acceptance and need for love. However, when psychological durability begins to gain strength, problem encountered is decline (Kartal, 2009). In current study found a relationship between disconnection and eating attitude and the relationship is not strong however, rejection was indirectly associated with eating attitude through psychological durability. One of the factors which increases the psychological durability is having healthy and satisfying relationship with other people

in daily life, particularly perceived social support is essential (Terzi, 2008). However, people who has disconnection schema suffer from insecure and unsatisfactory attachment, in this way their psychological durability decreases. From this perspective, having disconnection schemas could lead to have low psychological durability in this way maladaptive eating attitude might be internalized.

The groups of schemas are enmeshment/ dependence, abandonment failure, pessimism and vulnerability to harm under the domain of impaired autonomy are found related to eating attitude in the present study. People who have these schemas struggle with the skills of setting a target and activation of a plan (Young, Klasko and Weishaar, 2003). Basic beliefs about failure is always active and their dieting effort could not attained the goal because, they leave before it reaches its targets. Therefore, their beliefs about failure become stronger. From this perspective, felling of failure could lead to low psychological durability. The individuals' expectations about deterioration of everything and the negative expectation of things which could go wrong, are blocked during eating behavior. Because, individual who has low psychological durability has tendency to escape from negative circumstances and they feel desperate in negative situation (Terzi, 2008). Consequently, all negative thinking is left during eating that could help the individual to conceive short term relief. In current study found a relationship between impaired autonomy and eating attitude and the relationship is not strong however, impaired autonomy was indirectly associated with eating attitude through psychological durability.

4.2. Limitations

Limitations of the study must be taken into account in the context of interpretation. Despite of the significant findings of the research, the current study includes various limitations. The risky group about eating attitude was determined by eating attitude score. The volunteered participants of the study, are not eating disorder patients who seek help for these problems. Besides, in order to state the risky group, 32+ eating attitude scores were extracted from the data. The clinic group was not included into study. However, when cut-off score were applied, the Cronbach Alpha Coefficients decreased .56 from to .87. For that reason the reliability of the study is on the decline. Therefore, the current study should be replicated without using cut off score and individuals who diagnosed with eating disorder should be added in the study. In this way, the effects of variables could be investigated more accurate.

Furthermore, according to literature findings, eating disorder has high comorbidity with anxiety, depression, obsessive-compulsive disorder (Fairburn & Harrison, 2003; Fairburn, 2008; Vardar & Erzengin, 2011) and personality disorders (Ro, Martinsen, Hoftart and Rosenvinge, 2005). For this reason, the information was not attached to the study, it could also be evaluated as limitations of the study.

The current research is limited to the examination of two emotion regulation strategies (i.e. cognitive reappraisal and suppression), in this point of fact it remains unclear whether individuals with disordered eating attitude have more or less skilled different in types of strategies. Furthermore, future studies may comprise the assessment of emotion regulation on eating disorders with in different diagnostic sub-groups.

4.3. Future Research

First, the procedure of the current study should be replicated in different sample for determining if similar finding are acquired. Conducting research on clinical samples and including a greater diversity of ethnicities, cities; different socio economic status and different family backgrounds would increase the generalizability of the findings.

Nock et al. (2008) presented that the total score of Emotional Reactivity Scale could be used in order to distinguish between participants with and without Axis I disorders (e.g. eating disorder). Starting from this point, future research could be focused on the differences.

It is essential to be informed that two particular mediating model were focused and there might be plausible alternative ordering of these constructs that might be investigated. The association between emotion reactivity and eating attitude could be examined through emotion regulation in further research in order to gain understanding about emotional process path.

Conducted mediation analysis could not be permitted to determine how a past negative orientation predicts eating attitude. Especially, although past negative orientation was related to emotional reactivity, emotional sensitivity and psychological durability in current study, it could not help to give explanations how negative orientation have effect on eating attitude. Therefore new mediators are needed in order to give explanations.

4.4. Clinical Implications and Contributions of the Present Study

Current study could not be grounded on causal relationship however, it was thought that the study is worthwhile due to early maladaptive schemas, emotion regulation, emotional reactivity and time perspective were evaluated altogether. The existing literature has discussed these variables separately, however the current study revealed these variables as a whole in to one model in order to insight the mechanism of action.

In contrast to emotional regulation literature, there is almost no research based on examining emotional reactivity in eating attitude. Moreover, to our knowledge, the current study is the first to measure early maladaptive schemas as predictor of emotional reactivity and, emotional reactivity predictor of eating attitude. Besides, time perspective was firstly applied on empirical research which related to maladaptive eating attitude. The indirect and direct mediational models provide to contribution to the literature with a specific model in order to intervene against the possible development of eating disorder. In particular, having past-negative and present fatalistic time perspective are an important predictor of disordered eating attitude. Moreover, impaired autonomy and disconnection also are an important predictor of disordered eating attitude through psychological durability.

The best treatment model is seen as cognitive behavioral therapy for eating disorder patients in spite of all, it could not enough for recovering of all patients (Fairburn & Harrison, 2003). In treatment, the combination of schema focus therapy and time perspective therapy method could escalate the effect of therapy. Specifically, as time orientation of past negative and present fatalistic are directly associated with eating attitude, these orientation could be taken into consideration into therapy. Individual with maladaptive time perspective profile may benefit from ‘‘time

perspective therapy'' (Zimbardo and Boyd, 1999; Sword et al., 2014) that focus on development of neglected time categories (Zimbardo and Boyd, 1999). Temporal framing which is defined as balanced time perspective is seen most adaptive method (BTP; Zimbardo and Boyd, 1999). The research mention that optimal time perspective profile consists of high scores on past positive, moderately high scores on future and present hedonistic and low scores on past negative and present fatalistic (Zimbardo and Boyd, 2008). According to information, decreasing scores of past negative time orientation on individual with maladaptive eating patter, could be effective. At the same time, patients with maladaptive eating attitude have a tendency to ignore themselves by self-sacrificing and struggles with secure and satisfactory attachment with others. Furthermore, they aim to put difficult targets to be achieved and fail to struggle to establish their identity. In order to gain acceptance, keep emotional touch or avoid negative evaluation, the patients put these conditions into action. As a result, these would be studied during the therapy sessions. The most important part, managing of psychological durability required to concentrate empirical and practical attention. Particularly, focusing on development of satisfying relationships is an essential because the schema of disconnection and psychological durability's common points are insecure, unsatisfactory relationship and lacking of social support.

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APPENDIX A

DEMOGRAFIC DATA FORM

1. **Cinsiyetiniz**: Kadın ( ) Erkek ( ) Diğer ( )
2. **Yaşınız: …….**
3. **Medeni Durumunuz**: Bekar ( ) Evli ( ) Boşanmış ( ) Diğer ( )7
4. **Anneniz**: Hayatta ( ) Hayatta değil ( )
5. **Babanız:** Hayatta ( ) Hayatta değil ( )
6. **Annenizin Eğitim Durumu:**
   Okuryazar Değil ( ) Ön lisans mezunu/ 2 senelik üniversite mezunu ( )
   İlkokul Mezunu ( ) Üniversite mezunu ( )
   Ortaokul veya dengi okul mezunu ( ) Lisansüstü yapmış (Master, doktora) ( )
   Lise veya dengi okul mezunu ( )

7. **Annenizin mesleği nedir? (Eğer anneniz emekli ise, şu an çalışmıyor ise veya hayatta değil ise, çalıştığı zamanki mesleği yazınız).**

   …….

8. **Babanızın Eğitim Durumu:**
   Okuryazar Değil ( ) Ön lisans mezunu/ 2 senelik üniversite mezunu ( )
   İlkokul Mezunu ( ) Üniversite mezunu ( )
   Ortaokul veya dengi okul mezunu ( ) Lisansüstü yapmış (Master, doktora) ( )
   Lise veya dengi okul mezunu ( )

9. **Babanızın mesleği nedir? (Eğer babanız emekli ise, şu an çalışmıyor ise veya hayatta değil ise, çalıştığı zamanki mesleğini yazınız.)**
   ……

10. **Anneniz ve babanız:**
    Evli ( ) Boşanmış ( ) Ayrı yaşıyor ( ) Birinin işi nedeniyle ayrı yaşıyor ( )

11. **Yaşamınızın en büyük bölümünün geçtiği yer?**
    Köy ( ) Büyükşehir [İstanbul, Ankara gibi…] ( )
    İlçe merkezi ( ) Diğer [yurtdışı gibi] ( )
    İl merkezi ( )

12. **Yaşamınızın en büyük bölümünün geçtiği bölge?**
    Ege ( ) Karadeniz ( ) Güneydoğu Anadolu ( )
    Marmara ( ) Doğu Anadolu ( ) Yurt Dışı ( )
    İç Anadolu ( ) Akdeniz ( )

13. **Şu an nerede yaşıyorsunuz?**
    Evde ( )
    Yurtta ( )
    Diğer [özel misafirhane, orduevi, vb.] ( )

14. **Şu anda kimlerle yaşıyorsunuz?**
    Ailemle yaşıyorum ( )
    Evde yalnız yaşıyorum ( )
    Yurtta yalnız yaşıyorum ( )
    Yurtta arkadaş/arkadaşlarla yaşıyorum ( )
    Evde arkadaşım / arkadaşlarımla beraber yaşıyoruz ( )

Akrabalarımla yaşıyorum ( )

15. Sizce aileniz hangi gelir dilimine girer?
Alt ( ) Alt-orta ( ) Orta ( ) Orta Üstü( ) Üst ( )

16. Siz ailenizi nasıl tanımlarsınız?

Geleneksel			Modern
1	**2**	**3**	**4**

17. Boyunuz: …….
18. Kilonunuz: …….
19. Boyunuzun kaç olmasını isterdiniz? …….
20. Kilonuzun kaç olmasını isterdiniz? …….

21. Kilonuzdan ne kadar memnunsunuz?
Çok Memnunum ( ) Memnunum ( )
Ne memnun ne değilim ( ) Memnun değilim ( ) Hiç memnun değilim ( )
22. Kilonuzdan memnun değilseniz:
Kilo almak istiyorum ( ) Kilo vermek istiyorum ( )

23. Son 6 ay içerisinde kilonuzda bir değişiklik oldu mu? Evet ( ) Hayır ( )
Cevabınız evetse:
Bu değişiklik hangi yönde oldu? Kilo aldım ( ) Kilo verdim ( )
Bu değişiklik isteyerek mi oldu? Evet ( ) Hayır ( )

24. Önümüzdeki 6 ay içerisinde kilo vermeyi planlıyor musunuz? Evet ( ) Hayır ( )

25. Şu an diyet yapıyor musunuz? Evet ( ) Hayır ( )

26. Şu anki bedeninizi nasıl tanımlarsınız?
Çok kilolu ( ) Normal ( ) Kilolu ( ) Zayıf ( ) Çok zayıf ( )

27. Bedeninizin nasıl olmasını isterdiniz?
Çok kilolu ( ) Normal ( ) Kilolu ( ) Zayıf ( ) Çok zayıf ( )

28. Ne sıklıkla spor ve (ya) egzersiz yapmaktasınız? (Hafta, ay şeklinde yazabilirsiniz) .....

APPENDIX B

TIME PERSPECTIVE SCALE

Yönerge: Her maddeyi okuyunuz ve "bu benim için ne kadar geçerli?" sorusunu yanıtlayınız. Ölçek üzerinde uygun kutucuğu işaretleyiniz. Lütfen hiçbir maddeyi atlamayarak maddelerin tümünü işaretleyiniz.

(1)Benim için hiç doğru değil
(2)Benim için doğru değil
(3)Kararsızım
(4)Benim için doğru
(5)Benim için çok doğru

1. Kişinin, arkadaşlarıyla eğlenmek üzere bir araya gelmes yaşamdaki en keyifli olaylardan birisi olduğuna inanıyorum.	1	2	3	4	5
2. Tanıdık çocukluk manzaraları, sesleri ve kokuları bir sürü harika anıyı geri getirir.					
3. Kader, yaşamımdaki pek çok şeyi belirler.					
4. Yaşamda neleri farklı yapmalıydım diye sık sık düşünürüm.					
5. Kararlarım, çoğunlukla etrafımdaki insanlardan ve olaylardan etkilenir.					
6. Bir günün, o günün sabahında planlanması gerektiğine inanırım.					
7. Geçmişim hakkında düşünmek beni mutlu eder.					
8. İçimden geldiği gibi davranırım.					
9. Eğer işler zamanında hallolmazsa, bunu dert etmem.					
10. Bir şeyi başarmak istediğim zaman, hedefler koyar ve o hedeflere ulaşmanın yollarını belirlerim.					
11. Geçmişime baktığımda hatırlanacak iyi şeylerin kötü şeylerden daha fazla olduğunu görüyorum.					
12. Sevdiğim bir müziği dinlerken zamanın farkına varmam.					
13. Yarına hazır olması gereken işleri ve gerekli diğer şeyleri yapmak, bu gece eğlenmekten önce gelir.					
14. Her şey olacağına varacağı için benim ne yaptığım pek de önemli değildir.					
15. Eskiden yaşamın nasıl olduğuna ilişkin öykülere bayılırım.					
16. Eski acı deneyimler kafamda durmadan tekrarlanır durur.					
17. Yaşamımı olabildiğince dolu dolu ve günü gününe yaşamaya çalışırım.					

18. Randevularıma geç kalmaktan rahatsız olurum.					
19. Mümkün olsaydı her günümü sanki son günümmüş gibi yaşardım.					
20. Geçirdiğim iyi zamanların mutlu anıları hemen aklıma gelir.					
21. Dostlarıma ve yetkililere karşı olan sorumluluklarımı zamanında yerine getiririm.					
22. Geçmişte, reddedilmeye ve kullanılmaya ilişkin payıma düşeni aldım.					
23. Kararlarımı, o an kafama estiği gibi alırım.					
24. Planlamaktansa, her günü olduğu gibi yaşarım.					
25. Geçmişim, düşünmek istemediğim hoş olmayan hatıralarla dolu.					
26. Yaşamıma heyecan katmak çok önemlidir.					
27. Geçmişte, bugün silebilmeyi istediğim hatalar yaptım.					
28. Yaptığın işten keyif almanın, işin zamanında bitirilmesinden daha önemli olduğunu düşünüyorum.					
29. Çocukluğuma özlem duyarım.					
30. Bir karar vermeden önce, artılarla eksileri tartarım.					
31. Risk almak yaşamımı sıkıcı olmaktan kurtarır.					
32. Yaşamın nereye gittiğine odaklanmaktansa, yaşam yolculuğunun kendisinin tadını çıkarmak benim için daha önemlidir.					
33. Olaylar nadiren beklediğim gibi gerçekleşir.					
34. Gençliğimin tatsız görüntülerini unutmak, benim için çok zordur.					
35. Eğer amaçlara, sonuçlara ya da ürünlere odaklanmak zorunda kalırsam, yaptığım işin sürecinden ve akışından keyif alamam.					
36. Bugünümden keyif alırken bile, kendimi benzer geçmiş deneyimlerimle karşılaştırmalar yaparken bulurum.					
37. Her şey o kadar çok değişiyor ki, gelecek için gerçekten bir plan yapılamaz.					
38. Yaşamım, benim dışımdaki şeyler tarafından kontrol ediliyor.					
39. Nasıl olsa elimden bir şey gelmeyeceği için, gelecek hakkında kaygılanmanın alemi yok.					
40. İstikrarlı şekilde ilerleyerek, işleri zamanında bitiririm					
41. Aile üyeleri eskiden yaşamın nasıl olduğundan bahsettiklerinde sıkılırım.					
42. Yaşamıma heyecan katmak için risk alırım.					
43. Yapılacak işler listesi hazırlarım.					

44. Aklımın sesinden çok, kalbimin sesini dinlerim.					
45. Yapılması gereken işler varsa, beni yolumdan ayıracak şeylere karşı koyabilirim.					
46. Anın heyecanıyla sürüklenir giderim.					
47. Yaşam bugün çok karmaşık; geçmişin basit yaşamını tercih ederdim.					
48. Davranışlarını tahmin edebildiğim arkadaşlardan çok, anlık ve içten geldiği gibi davranan arkadaşları tercih ederim.					
49. Aile geleneklerini ve düzenli olarak tekrarlanan aile toplantılarını severim.					
50. Geçmişte başıma gelen kötü şeyler hakkında düşünürüm.					
51. Eğer ilerlememe yardım edecekse, zor ve ilgimi çekmeyen işleri yapmaya devam ederim.					
52. Kazandığımı, yarının güvenliği için saklamaktansa bugünün keyfi için harcamak daha iyidir.					
53. Genellikle şans, sıkı çalışmaktan daha çok kazandırır.					
54. Yaşamımda hep kaçırdığım güzellikleri düşünürüm.					
55. Yakın ilişkilerimin tutkulu olmasını isterim.					
56. Her zaman çalışmalarımı tamamlamaya yetecek zamanım olacaktır.					

APPENDIX C

YOUNG SCHEMA QUESTIONNAIRE

Yönerge: Aşağıda, kişilerin kendilerini tanımlarken kullandıkları ifadeler sıralanmıştır. Lütfen her bir ifadeyi okuyun ve sizi ne kadar iyi tanımladığına karar verin. Emin olamadığınız sorularda neyin doğru olabileceğinden çok, sizin **duygusal olarak** ne hissettiğinize dayanarak cevap verin. Bir kaç soru, anne babanızla ilişkiniz hakkındadır. Eğer biri veya her ikisi şu anda yaşamıyorlarsa, bu soruları o veya onlar hayatta iken ilişkinizi göz önüne alarak cevaplandırın. 1'den 6'ya kadar olan seçeneklerden sizi tanımlayan en yüksek şıkkı seçerek her sorudan önce yer alan boşluğa yazınız.

Derecelendirme:

1- Benim için tamamıyla yanlış

2- Benim için büyük ölçüde yanlış

3- Bana uyan tarafı uymayan tarafından biraz fazla

4- Benim için orta derecede doğru

5- Benim için çoğunlukla doğru

6- Beni mükemmel şekilde tanımlıyor

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1. _____ Bana bakan, benimle zaman geçiren, başıma gelen olaylarla gerçekten ilgilenen kimsem olmadı.
2. _____ Beni terk edeceklerinden korktuğum için yakın olduğum insanların peşini bırakmam.
3. _____ İnsanların beni kullandıklarını hissediyorum.
4. _____ Uyumsuzum.
5. _____ Beğendiğim hiçbir erkek/kadın, kusurlarımı görürse beni sevmez.
6. _____ İş (veya okul) hayatımda neredeyse hiçbir şeyi diğer insanlar kadar iyi yapamıyorum.
7. _____ Günlük yaşamımı tek başıma idare edebilme becerisine sahip olduğumu hissetmiyorum.
8. _____ Kötü bir şey olacağı duygusundan kurtulamıyorum.
9. _____ Anne babamdan ayrılmayı, bağımsız hareket edebilmeyi, yaşıtlarım kadar, başaramadım.
10. _____ Eğer istediğimi yaparsam, başımı derde sokarım diye düşünürüm.
11. _____ Genellikle yakınlarıma ilgi gösteren ve bakan ben olurum.
12. _____ Olumlu duygularımı diğerlerine göstermekten utanırım (sevdiğimi, önemsediğimi göstermek gibi).
13. _____ Yaptığım çoğu şeyde en iyi olmalıyım; ikinci olmayı kabullenemem.
14. _____ Diğer insanlardan bir şeyler istediğimde bana "hayır" denilmesini çok zor kabullenirim.
15. _____ Kendimi sıradan ve sıkıcı işleri yapmaya zorlayamam.

16. _____ Paramın olması ve önemli insanlar tanıyor olmak beni değerli yapar.

17. _____ Her şey yolunda gidiyor görünse bile, bunun bozulacağını hissederim.

18. _____ Eğer bir yanlış yaparsam, cezalandırılmayı hak ederim.

19. _____ Çevremde bana sıcaklık, koruma ve duygusal yakınlık gösteren kimsem yok.

20. _____ Diğer insanlara o kadar muhtacım ki onları kaybedeceğim diye çok endişeleniyorum.

21. _____ İnsanlara karşı tedbiri elden bırakamam yoksa bana kasıtlı olarak zarar vereceklerini hissederim.

22. _____ Temel olarak diğer insanlardan farklıyım.

23. _____ Gerçek beni tanırlarsa beğendiğim hiç kimse bana yakın olmak istemez.

24. _____ İşleri halletmede son derece yetersizim.

25. _____ Gündelik işlerde kendimi başkalarına bağımlı biri olarak görüyorum.

26. _____ Her an bir felaket (doğal, adli, mali veya tıbbi) olabilir diye hissediyorum.

27. _____ Annem, babam ve ben birbirimizin hayatı ve sorunlarıyla aşırı ilgili olmaya eğilimliyiz.

28. _____ Diğer insanların isteklerine uymaktan başka yolum yokmuş gibi hissediyorum; eğer böyle yapmazsam bir şekilde beni reddederler veya intikam alırlar.

29. _____ Başkalarını kendimden daha fazla düşündüğüm için ben iyi bir insanım.

30. _____ Duygularımı diğerlerine açmayı utanç verici bulurum.

31. _____ En iyisini yapmalıyım, "yeterince iyi" ile yetinemem.

32. _____ Ben özel biriyim ve diğer insanlar için konulmuş olan kısıtlamaları veya sınırları kabul etmek zorunda değilim.

33. _____ Eğer hedefime ulaşamazsam kolaylıkla yılgınlığa düşer ve vazgeçerim.

34. _____ Başkalarının da farkında olduğu başarılar benim için en değerlisidir.

35. _____ İyi bir şey olursa, bunu kötü bir şeyin izleyeceğinden endişe ederim.

36. _____ Eğer yanlış yaparsam, bunun özürü yoktur.

37. _____ Birisi için özel olduğumu hiç hissetmedim.

38. _____ Yakınlarımın beni terk edeceği ya da ayrılacağından endişe duyarım

39. _____ Herhangi bir anda birileri beni aldatmaya kalkışabilir.

40. _____ Bir yere ait değilim, yalnızım.

41. _____ Başkalarının sevgisine, ilgisine ve saygısına değer bir insan değilim.

42. _____ İş ve başarı alanlarında birçok insan benden daha yeterli.

43. _____ Doğru ile yanlışı birbirinden ayırmakta zorlanırım.

44. _____ Fiziksel bir saldırıya uğramaktan endişe duyarım.

45. _____ Annem, babam ve ben özel hayatımız birbirimizden saklarsak, birbirimizi aldatmış hisseder veya suçluluk duyarız

46. _____ İlişkilerimde, diğer kişinin yönlendirici olmasına izin veririm.

47. _____ Yakınlarımla o kadar meşgulüm ki kendime çok az zaman kalıyor.

48. _____ İnsanlarla beraberken içten ve cana yakın olmak benim için zordur.

49. _____ Tüm sorumluluklarımı yerine getirmek zorundayım.

50. _____ İstediğimi yapmaktan alıkonulmaktan veya kısıtlanmaktan nefret ederim.

51. _____ Uzun vadeli amaçlara ulaşabilmek için şu andaki zevklerimden fedakârlık etmekte zorlanırım

52. _____ Başkalarından yoğun bir ilgi görmezsem kendimi daha az önemli hissederim.

53. _____ Yeterince dikkatli olmazsanız, neredeyse her zaman bir şeyler ters gider.

54. _____ Eğer işimi doğru yapmazsam sonuçlara katlanmam gerekir.

55. _____ Beni gerçekten dinleyen, anlayan veya benim gerçek ihtiyaçlarım ve duygularımı önemseyen kimsem olmadı.

56. _____ Önem verdiğim birisinin benden uzaklaştığını sezersem çok kötü hissederim.

57. _____ Diğer insanların niyetleriyle ilgili oldukça şüpheciyimdir.

58. _____ Kendimi diğer insanlara uzak veya kopmuş hissediyorum.

59. _____ Kendimi sevilebilecek biri gibi hissetmiyorum.

60. _____ İş (okul) hayatımda diğer insanlar kadar yetenekli değilim.

61. _____ Gündelik işler için benim kararlarıma güvenilemez.

62. _____ Tüm paramı kaybedip çok fakir veya zavallı duruma düşmekten endişe duyarım.

63. _____ Çoğunlukla annem ve babamın benimle iç içe yaşadığını hissediyorum-Benim kendime ait bir hayatım yok.

64. _____ Kendim için ne istediğimi bilmediğim için daima benim adıma diğer insanların karar vermesine izin veririm.

65. _____ Ben hep başkalarının sorunlarını dinleyen kişi oldum.

66. _____ Kendimi o kadar kontrol ederim ki insanlar beni duygusuz veya hissiz bulurlar.

67. _____ Başarmak ve bir şeyler yapmak için sürekli bir baskı altındayım.

68. _____ Diğer insanların uyduğu kurallara ve geleneklere uymak zorunda olmadığımı hissediyorum.

69. _____ Benim yararıma olduğunu bilsem bile hoşuma gitmeyen şeyleri yapmaya kendimi zorlayamam.

70. _____ Bir toplantıda fikrimi söylediğimde veya bir topluluğa tanıtıldığımda onaylanılmayı ve takdir görmeyi isterim.

71. _____ Ne kadar çok çalışırsam çalışayım, maddi olarak iflas edeceğimden ve neredeyse her şeyimi kaybedeceğimden endişe ederim.

72. _____ Neden yanlış yaptığımın önemi yoktur; eğer hata yaptıysam sonucuna da katlanmam gerekir.

73. _____ Hayatımda ne yapacağımı bilmediğim zamanlarda uygun bir öneride bulunacak veya beni yönlendirecek kimsem olmadı.

74. _____ İnsanların beni terk edeceği endişesiyle bazen onları kendimden uzaklaştırırım.

75. _____ Genellikle insanların asıl veya art niyetlerini araştırırım.

76. _____ Kendimi hep grupların dışında hissederim.

77. _____ Kabul edilemeyecek pek çok özelliğim yüzünden insanların kendimi açamıyorum veya beni tam olarak tanımalarına izin vermiyorum.

78. _____ İş (okul) hayatımda diğer insanlar kadar zeki değilim.

79. ____ Günlük yaşamımı tek başıma idare edebilme becerisine sahip olduğumu hissetmiyorum.

80. _____ Bir doktor tarafından herhangi bir ciddi hastalık bulunmamasına rağmen bende ciddi bir hastalığın gelişmekte olduğu endişesine kapılıyorum.

81. _____ Sık sık annemden babamdan ya da eşimden ayrı bir kimliğimin olmadığını hissediyorum.

82. _____ Haklarıma saygı duyulmasını ve duygularımın hesaba katılmasını istemekte çok zorlanıyorum.

83. _____ Başkaları beni, diğerleri için çok, kendim için az şey yapan biri olarak görüyorlar.

84. _____ Diğerleri beni duygusal olarak soğuk bulurlar.

85. _____ Kendimi sorumluluktan kolayca sıyıramıyorum veya hatalarım için gerekçe bulamıyorum.

86. _____ Benim yaptıklarımın, diğer insanların katkılarından daha önemli olduğunu hissediyorum.

87. _____ Kararlarıma nadiren sadık kalabilirim.

88. _____ Bir dolu övgüler ve iltifat almam kendimi değerli birisi olarak hissetmemi sağlar.

89. _____ Yanlış bir kararın bir felakete yol açabileceğinden endişe ederim.

90. _____ Ben cezalandırılmayı hak eden kötü bir insanım.

APPENDIX D

EATING ATTITUDE TEST (EAT- 40)

Yönerge: Bu anket sizin yeme alışkanlıklarınızla ilgilidir. Lütfen her bir soruyu dikkatlice okuyunuz ve size en uygun gelen kutu içine (x) işareti koyunuz. Örneğin ‘’ Çikolata yemek hoşuma gider’’ cümlesini okudunuz. Çikolata yemek hiç hoşunuza gitmiyorsa ‘’hiçbir zaman’’ yazılı kutu içine (x) işareti koyunuz; her zaman hoşunuza gidiyorsa ‘’ daima’’ nın altını (x) ile işaretleyiniz.

	Daima	**Çok sık**	**Sık sık**	**Bazen**	**Nadiren**	**Hiçbir**
1. Başkaları ile birlikte yemek yemekten hoşlanırım.						
2. Başkaları için yemek pişiririm, fakat pişirdiğim yemeği sevmem.						
3. Yemekten önce sıkıntılı olurum.						
4. Şişmanlıktan ödüm kopar.						
5. Acıktığımda yemek yememeye çalışırım.						
6. Aklım fikrim yemektedir.						
7. Yemek yemeyi durduramadığım zamanlar olur.						
8. Yiyeceğimi küçük küçük parçalara bölerim.						
9. Yediğim yiyeceğin kalorisini bilirim.						
10. Ekmek, patates, pirinç, gibi yüksek kalorili yiyeceklerden kaçınırım.						
11. Yemeklerden sonra şişkinlik hissederim.						
12. Ailem fazla yememi bekler.						
13. Yemek yedikten sonra kusarım.						
14. Yemek yedikten sonra aşırı suçluluk duyarım.						

15. Tek düşüncem daha zayıf olmaktır.						
16. Aldığım kalorileri yakmak için yorulana kadar egzersiz yaparım.						
17. Günde birkaç kez tartılırım.						
18. Vücudumu saran dar elbiselerden hoşlanırım.						
19. Et yemekten hoşlanırım.						
20. Sabahları erken uyanırım.						
21. Günlerce aynı yemeği yerim.						
22. Egzersiz yaptığımda harcadığım kalorileri hesaplarım.						
23. Adetlerim düzenlidir.						
24. Başkaları zayıf olduğumu düşünür.						
25. Şişmanlayacağım (vücudumun yağ toplayacağı) düşüncesi zihnimi meşgul eder.						
26. Yemeklerimi yemek başkalarınınkinden uzun sürer.						
27. Lokantada yemek yemeği severim						
28. Müshil kullanırım.						
29. Şekerli yiyeceklerden kaçınırım.						
30. Diyet (perhiz) yemekleri yerim.						
31. Yaşamımı yiyeceğin kontrol ettiğini düşünürüm.						
32. Yiyecek konusunda kendimi denetleyebilirim.						
33. Yemek konusunda başkalarının bana baskı yaptığını düşünürüm.						
34. Yiyeceklerle ilgili düşünceler çok zamanımı alır.						
35. Kabızlıktan yakınırım						
36. Tatlı yedikten sonra rahatsız olurum.						
37. Perhiz yaparım.						
38. Midemin boş olmasından hoşlanırım.						
39. Şekerli, yağlı yiyecekleri denemekten hoşlanırım.						
40. Yemeklerden sonra içimden kusmak gelir.						

APPENDIX E

EMOTION REGULATION SCALE

Yönerge: Lütfen her maddeyi okuduktan sonra, o maddede belirtilen fikre katılma derecenizi ‘’Tamamen Katılıyorum’’ ve ‘‘Hiç Katılmıyorum’’ arasında değişen ifadelerden size uygun olanı işaretleyerek belirtiniz.

	Hiç Katılmıyorum	**Katılmıyorum**	**Biraz Katılmıyorum**	**Kararsızım**	**Biraz Katılıyorum**	**Katılıyorum**	**Tamamen Katılıyorum**
1. İçinde bulunduğum duruma göre düşünme şeklini değiştirerek duygularımı kontrol ederim.							
2. Olumsuz duygularımın az olmasını istersem, durumla ilgili düşünme şeklimi değiştiririm.							
3. Olumlu duygularımın fazla olmasını istediğim zaman duruma ilgili düşünme şeklimi değiştiririm.							
4. Olumlu duygularımın fazla olmasını istersem (mutluluk veya eğlence) düşündüğüm şeyi değiştiririm.							
5. Olumsuz duygularımın az olmasını istersem (kötü hissetme veya kızgınlık gibi) düşündüğüm şeyi değiştiririm.							
6. Stresli bir durumla karşılaştığımda, bu durumu sakin kalmamı sağlayacak şekilde düşünmeye çalışırım.							
7. Duygularımı ifade etmeyerek kontrol ederim.							
8. Olumsuz duygular hissettiğimde onları ifade etmediğimden emin olmak isterim.							
9. Duygularımı kendime saklarım.							
10. Olumlu duygular hissettiğimde onları ifade etmemeye dikkat ederim.							

APPENDIX F

EMOTIONAL REACTIVITY SCALE

Yönerge: Lütfen aşağıdaki sorularda belirtilen durumların sizdekine ne kadar uyduğunu değerlendiriniz ve her soru için buna uyan cevabı işaretleyiniz.

	Tamamen Katılıyorum	**Katılıyorum**	**Katılmıyorum**	**Hiç Katılmıyorum**
1. Üzücü olaylar karşısında çok kolayca duygusallaşırım.				
2. Çok küçük şeyler bile beni duygusallaştırır.				
3. Bir duyguyu yaşadığımda çok yoğun yaşarım.				
4. Üzücü bir şey yaşadığımda, uzun bir süre ona kafa yorarım.				
5. Duygularımı çok yoğun yaşarım.				
6. Duygularımda ani iniş-çıkışlar yaşadığım olur.				
7. Bir duyguyu yaşadığımda başka bir duyguyu yaşamak benim için çok zordur.				
8. Benim için mantıklı/ düzgün düşünmek zordur, bu yüzden kendimi genellikle mutsuz hissederim.				
9. Duygusal olarak çok çabuk incinirim.				
10. Kızgın olduğumda çevremdekiler beni zor sakinleştirir.				
11. Kendimi genellikle endişeli hissederim.				
12. Diğer insanların önemsemediği şeylere çok kafa yorarım.				
13. Üzücü bir durum karşısında kolayca dağılırım.				
14. Çevremdekiler olaylara aşırı tepki verdiğimi söyler.				
15. Kötü bir olay yaşadığımda, ruh halim hızlıca değişir.				

16. Çevremdekiler olaylar karşısında sakinliğimi koruyamadığımı söyler.				
17. Eğer biriyle bir anlaşmazlık yaşarsam, bu durumu kafamdan atmam zaman alır.				