THE RELATION BETWEEN EATING ATTITUDES, ATTACHMENT AND EMOTION REGULATION

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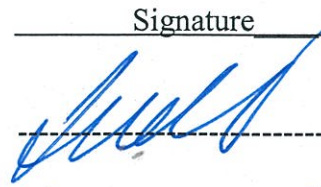
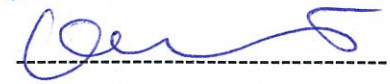
Thesis Supervisor Dr. Serkan ÖZGÜN	
Member Assist. Prof. Ayşe Meltem BUDAK	
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ABSTRACT

THE RELATION BETWEEN EATING ATTITUDES, ATTACHMENT AND EMOTION REGULATION DIFFICULTY

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This study aims to investigate the relationship between eating attitudes, attachment and emotion regulation. The main objective was to test the predictor role of attachment dimension and emotion regulation difficulties on eating attitudes of a non-clinical sample. The participants were consisted of 294 students, aged between 18-33, from two public and private colleges. Correlation and regression analysis conducted to examine the prediction roles. The results showed that among attachment dimensions and emotion regulation difficulties, anxious attachment, having difficulty in finding goal oriented behavior and adaptive strategies and being aware of emotions were related with disordered eating attitudes. However, among the relational factors, only anxious attachment and having difficulty in being aware of emotions found as the predictor of eating attitudes.

Keywords: eating attitudes, eating disorder, attachment, emotion, emotion regulation, emotion regulations difficulties.

ÖZ

YEME TUTUMLARINI BAĞLANMA VE DUYGU DÜZENLEME İLE İLİŞKİSİ

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Bu çalışma yeme tutumları bağlanma ve duygu regülasyonu arasındaki ilişkiyi araştırmayı amaçlamaktadır. Araştırmanın temel hedefi, bağlanma boyutlarının ve duygu regülasyon güçlüğünün klinik tanı almamış kişilerin yeme tutumlarını yordamaktır. Araştırmanın örneklemini İstanbul'un devlet ve özel üniversitelerinde okuyan yaşları 18-33 arasında değişen 294 üniversite öğrencisi oluşturmaktadır. Yordayıcı rolü incelemek amacıyla bağlanma boyutları ve duygu regülasyon güçlükleri arasında korelasyon ve regresyon analizleri yapılmıştır. Sonuçlar, kaygılı bağlanmanın, duyguların farkında olmanın, amaç odaklı davranışlar sergilemenin ve stratejiler geliştirmekte zorlanmanın bozulmuş yeme tutumları ile ilişkisini doğrulamıştır. Fakat sadece kaygılı bağlanma ve duyguların farkında olmakta zorlanmanın yeme tutumu üzerinde yordayıcı etkisi bulunmuştur.

Anahtar sözcükler: yeme tutumu, yeme bozukluğu, bağlanma, duygu, duygu düzenleme, duygu düzenleme

TABLE OF CONTENTS

LIST OF TABLES

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CHAPTER 1

INTRODUCTION

1.1 Statement of the Problem

Eating attitudes are our positive and negative evaluations, feelings, thoughts and behaviors that state our relationship with food (Alvarenga & Scagliusi & Philippi, 2012). The literature revealed that eating attitudes could vary depending on cultural differences, social preferences and psychological status. This study focuses on the evolution of eating attitudes depending on psychological determinants.

Eating attitudes refers to a dimension that consists of a range between healthy and disordered eating behaviors. However, because of the media emphasis on thinness, body dissatisfaction, weight control and dieting the cluster of disordered eating have been expanding since last 10 years. A study done by Meyer (2005) pointed out that 25% of females exhibit disordered eating however, they were not aware of their own symptoms. Additionally, the prevalence rate increased between 35%-50% of young females had nonclinical eating disorder symptoms in U.S. (Berg, K. C., Frazier, P., & Sherr, L., 2009). Even though the subclinical prevalence rates are not known clearly in Turkey, the increased prevalence rate of eating disorders are indicating the threat of increasing disordered eating attitudes.

Depending on the literature there are various psychological determinants of disordered eating. Yet, among all determinants attachment and emotion regulation are the most salient and focused ones for years.

Attachment refers to the infant mother relationship that consists of the cognitive, affective and behavioral representations of later interpersonal relationships (Biringen, 1994). With secure attachment, the infant learns to explore the world and sooth the self in stress-evoking situations (Biringen, 1994; Lopez & Brennan, 2000). However, when the mothers' reactions and behaviors were not satisfying for the infant, then unsecure attachment bond was established. According to the unsecure attachment, the infant become more avoidant or anxious towards later relationships in life. As eating attitudes were described as the relationship with food, they also affected from the attachment as well.

Attachment also influences the ability to regulate emotions functionally. Emotion regulation difficulty emerges when the effective regulation strategies are not utilized when confronted to a negative emotion-evoking situation (Koole, 2009; Cole, Michel, & Teti, 1994). Therefore, nonfunctional strategies such as eating that appear as a temporary solution for the negative emotions (Cole, & Hall, 2001).

Thus, as previous studies noted attachment and emotion regulation are the two significant domains while understanding eating attitudes. The current study aims to investigate the critical role of attachment and emotion regulation on eating attitudes.

1.2 Eating Disorders

According to the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders Text Revision, Eating Disorders are classified into three clusters as anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified (2000).

The anorexia nervosa type also divided into two groups as restricting and binge-purge type. First, the restricting type aims to loose weight although the thinness has already achieved by restricting calorie intake through fasting, dieting or doing excessive exercise. Second, the binge/purge type of the anorexia nervosa is developed when overeating compensated with self-induced vomiting, using laxatives, diuretics, and enemas and follows with binge eating again. The core features of anorexia nervosa are the distorted perception about the body weight, dissatisfaction with thinness and extreme fear of gaining weight. The diagnosis is given when the person's weight is fifteen percent under from the expected weight and loses her menstrual cycle as a consequence of malnutrition (Maner, 2001).

The second type of Eating Disorder is bulimia nervosa is associated with binge eating especially with the feeling of losing control. The people with bulimia nervosa classified as two ways while neutralizing the fear of binges. The purging type use self-induced vomiting, use of laxatives, diuretics or enemas. The non-purging type use fasting, doing excessive exercise but not engage in self-vomiting and use of misuse of laxatives, diuretics or enemas. The diagnosis is given when the

binge eating and compensatory behaviors lasts at least twice a week for three months (Maner, 2001).

There are several differences between individuals with anorexia nervosa or bulimia nervosa. First, as a consequence of binges, individuals with bulimia nervosa prevent gaining weight but individuals with anorexia nervosa try losing weight. Second, individuals with anorexia nervosa are obviously seemed unhealthier than individuals with bulimia nervosa due to the weight loss. Third, individuals with bulimia nervosa are afraid of losing control between and during binges, however, individuals with anorexia nervosa are proud of the control about restricting food and fasting. Fourth, individuals with anorexia nervosa have more distorted perception about the body weight and have strong resistance to treatment; on the other hand, individuals with bulimia nervosa are more aware of the disorder and willing to be treated.

The last type of the Eating Disorders is Eating Disorder Not Otherwise Specified (NOS) (American Psychiatric Assosiciation, 2000). The diagnosis is given when the symptoms are available but not fulfill all of the criteria for a diagnosis of anorexia nervosa or bulimia nervosa.

1.2.1 Prevalence and Incidence Rates in the World and in Turkey

There are many studies that indicated the increase in prevalence and incidence rates of eating disorders. To start with the world statistics, research results showed that the prevalence rate of anorexia nervosa had increased from 0.3% to 0.7% between 1990 and 1997 among adolescents aged 13-18 (Whitaker, Johnson,

Shaffer, Rapoport, Kalikow, Walsh, Davies, Braiman, & Dolinsky, 1990; Steinhausen, Winkler, & Meier, 1990). In addition to this, the incidence rate of anorexia nervosa was 1.60% between the years 1960-1969 (Kendell, Hall, Hailey, & Babigian, 1973). Second, the prevalence rate of bulimia was found increased from 0.5% to 0.8% between 1996 and 2002 (Santonastaso, Zanetti, Sala, Favaretto, Vidotto, & Favaro, 1996; Gual, Perez-Gaspar, Martinez-Gonzalez, Lahortiga, Irala-Estevez, & Cervera-Enguix, 2002). Another study conducted in 2003 demonstrated that for anorexia nervosa prevalence rate was 0.5% and bulimia nervosa prevalence rate was to 1-3%. (Klein & Walsh, 2003) In addition to this, the gender ratio for anorexia nervosa was 10-20:1, female; male but for bulimia nervosa was 10:1, female: male in US (Klein & Walsh, 2003).

Furthermore, compared to the past decades, nowadays eating disorders considered as a common psychological disorder for both males and females in Turkey. The study conducted by Yeşilbursa (1990) demonstrated the bulimia nervosa prevalence rate was 4.31% for females and 0.63% for males and this rate for anorexia nervosa was 0.29% for females and 0.1% for males among students aged 14-19 (Yeşilbursa, 1990).

The research done in 2006 (Uzun, Güleç, Özşahin, Doruk, Özdemir, & Çalışkan) showed that among the 414 female college students the anorexia nervosa prevalence rate was 0.5%, which was consistent with U.S. anorexia nervosa prevalence findings. However, 0.5% prevalence rate was for bulimia nervosa showed that there were lower people with bulimia nervosa in Turkey than in U.S.

On the other hand, another study done with 300 late adolescents found that the prevalence rate for bulimia nervosa was 1.3% and the ratio was equal for females and males (Kızıltan, Karabudak, Ünver, Sezgin, & Ünal, 2006).

Lastly, study was conducted in Gazi University, Ankara, with 610 students, 338 males and 272 females (Şanlıer, Yabancı, & Alyakut, 2008). The findings revealed that the 22.8% of students were diagnosed with Eating Disorders. Despite of the fact that most of the studies manifested the increasing rates of eating disorders, the distinctions between some results are due to different sample sizes and characteristics.

Empirical findings pointed out that nonclinical eating disorders are not adequate enough to get a diagnosis, nevertheless the increasing rates of exhibiting eating disorders symptoms have been increasing by the time. Thes blurry line between disordered eating and eating disorders that becomes clear and more visible by investigation of the impact of that behavior for one's life. When the disordered eating attitudes do not spread various areas such as daily, social and occupational lives and additionally disturb one's cognition and behavior at a sub-clinical level, then besides disorder, a maladaptive eating attitude comes into account.

1.3 Eating Attitudes

Eating is a fundamental necessity for maintaining healthy life. Beyond its physiological significance, cultural, social and psychological aspects interpret and explain the meaning of eating and its value in various kinds of relationships.

Therefore, it becomes a concept that describes one's attitudes apart from its function as a behavior (Alvarenga et al., 2012). Attitudes defined as the long lasting clusters of feelings, beliefs and cognitions are derived from positive or negative evaluations that lead to actions coherent with those cognitions and feelings towards that specific person, object and idea (Oppenheim, 1966; Aronson, 2007).

When the attitudes were interpreted in terms of eating, "eating attitude" stands for one's positive or negative evaluations, feelings, thoughts, behaviors and relationship with food (Alvarenga et al., 2012). To begin with, one of the main components of eating attitude is the feeling aroused by the food preference. In line with that idea, Rozin (1999) also conceptualized and pointed out food's significance as being "*the contributor for the physical well being and a major source of pleasure, worry and stress*". In their study, Rozin and his friends examined the way of food that operates in people's minds and lives comparing four cultures, Belgian, French, American and Japanese. The investigation was based on four different aims: understanding the psychology of food; searching positive (pleasure, social facilitation and anticipation) or negative (worry, fear, dread) aspects of food; determining the relationship between diet and health; comparing the significance and interpretation of food among different cultures. The attitudes of the food preferences were assessed with a structured questionnaire. It was found that, in terms of gender, women significantly worried more than men and modified their diet with reduced salt/fat foods due to their concern of weight, body shape and appearance. Additionally, women considered their current body appearance fatter than the ideal. Among cultures, French and Belgians were getting the most pleasure; Japanese got moderate pleasure from food compared to Americans. Lastly, few Americans, some

Japanese and most of Belgians and French believed their own sense of being healthy eaters (Rozin et al., 1999). Consequently, eating attitudes could be affected and vary depending on the definite conditions such as being women or men or belonging to a different culture.

As the eating attitudes differ among cultures, Rozin, Kurzer and Cohen (2002) searched the meaning of word "food" with free association comparing participants from United States, France and India. Free association was chosen because of its plain demonstration of explicit attitudes while encountering an event. The associated words were categorized as positive, negative and neutral valence. The results showed that women and American participants used the word "fat" more compared to men and French and Indian participants. The high frequency of the word "fat" interpreted as women's traditional homemaker role. Additionally, Americans' worry and focus was found on the content of food but not experience of eating. Comparing attitudes, Indians had more positive associations to food than Americans and French that Indians got more pleasure from food (Rozin, 2002).

Besides cultural aspect, social and psychological aspects of eating attitudes intertwined and related to one another. The study done by Fuglestad (2013) examined the relations of psychological well being and eating behaviors with the eating related attitudinal consistency between self and friend according to balance theory. Briefly, balance theory suggested that people seek consistency in their interpersonal relationships. Based on our favorability, we want to agree with people we like but disagree with people we dislike (Heider, 1958). Participants' eating attitude, psychological well being and eating behavior information were collected

with questionnaires. The findings demonstrated that the greater psychological well being was related to the consistent eating attitudes with self and perceptions of friends (Fuglestad, 2003). To explain, if one cared about healthy eating and perceives one's friends also cared had lower depression, greater self-esteem and body dissatisfaction compared to one whose friend did not care about healthy eating. The discrepancy could be explained due to the fact that inconsistencies were perceived as a judgement or threat (Fuglestad, 2003).

Overall, eating attitudes have easily changeable dynamics depending on the stable conditions, gender and culture and unsteady conditions, social life and psychological well-being. Therefore, the change from healthy to disordered eating attitudes was possible while encountering with negative events in social life and decreasing psychological wellness.

1.3.1 Disordered Eating Attitudes in Nonclinical Sample

The literature illustrated that eating attitudes that were affected from cultural, social and psychological aspects determines one's eating behavior. According to the attitudes, one's eating behavior changes in a continuum that has two extremes as feeling pleasure and eating healthy or feeling worry and disordered eating. To clarify, disordered eating means having ambivalent feelings and a problematic relationship with food accompanied with problematic eating behaviors. Thus, despite eating disorders belong to that side of the continuum; there is also a non-clinical group with various eating problems. Various studies revealed that in nonclinical group significant amount of people suffer from eating problems, especially adolescents and young adult women (American Psychiatric Association, 1994). Berg

et al. (2009) found that, in U.S between 35%-50% of young females experience eating problems and did not meet the DSM-IV criteria. Another study that investigated the psychological correlation with treatment seeking results showed that 25% of the female college women exhibited eating disorder symptoms in subclinical level and 75% in clinical level. Yet, 78% of the participants showed nonclinical bulimic symptoms (Meyer, 2005). Additional significant finding indicated that out of 15% eating disordered participants only 3% of them were aware of their symptoms and seeing a therapist for their eating problems (Meyer, 2005). Lastly, the risk of eating disorder development was found as higher in the first year in college because of age, developmental factors, increased dieting behavior, depression and environmental and academic stressors (Krahn, Kurth, Gomberg, & Drewnowski, 2005; Stice, 2002; Hoyt & Ross, 2003; Compas, Wagner, Slavin, & Vannatta, 1986). The study inquired the eating disorder symptomatology in colleges and universities in U.S. demonstrated that 35-70% of the women population show direct or indirect symptoms of disordered eating by having unhealthy weight fluctuations, excessive weight, fat and calorie monitoring, loss of appetitive control, purging or doing excessive exercise to inhibit weight gain (Hoyt & Ross, 2003; Krahn, Kurth, Gomberg, & Drewnowski, 2005; Heatherton, Nichols, Mahamedi, & Keel, 1995).

1.3.1.1 Gender Differences in Disordered Eating Attitudes

The previous studies demonstrated that women and men have different eating attitudes (Rozin, 2002; Meyer, 2005; Hoyt & Ross, 2003). Rozin, Bauer and Catanese (2003) exhibited that among 2,200 undergraduates %14 of the women felt embarrassed to buy a chocolate bar in the store and have more concerns about eating and food compared to men. In addition to this, although more men than women

reported overeating, more women than men declared to feel uncontrollable eating that resembles binge eating (Striegel-Moore, Roselli, Perrin, DeBar, Wilson, May, Kraemer, 2009). Moreover, as Pettit, Jacobs, Page & Porras (2010) found out women had more tendencies toward dieting and food preoccupation than men. Therefore, compared to men, women's disordered eating attitudes have been showing an increasing pattern.

Yet, significant to remember that, a disordered attitude is not emerged by only one factor but rather developed with the contribution of broad range of factors such as being female, childhood abuse, low self-esteem, media emphasis on thinness, dieting, having comorbid depression and obsessive compulsive disorder symptoms, body dissatisfaction, attachment and difficulty in emotion regulation as previously mentioned. (Baylan, Kılıçoğlu, & Erol, 2009; Streigel-Moore & Bulik, 2007; Beato-Farnandez, Rodriguez-Cano, Belmonte-Llario, & Martinez-Delgado, 2004; Ghaderi, & Scott, 2001; Kuğu, Akyuz, Dogan, Ersan, & Izgic, 2006)

Considering eating attitudes as a way of self-expression, among those factors attachment dimension and emotion regulation difficulty could be obviously detected from eating behavior. As literature suggested, insecure attachment leads to poor emotion regulation that eating by itself became a nonadaptive and unfunctional emotion regulation strategy (Ramaciotti et al., 2001; Candelori & Ciocca, 1998; Cole & Hall, 2001; Deaver et al., 2003). Thus, the current study aims to examine the relationship and predictor role of eating attitudes with attachment and emotion regulation.

1.4 Attachment

The attachment concept emerged through the Bowlby's curiosity about the relation between the maternal loss, separation or deprivation and personality development and improved with Ainsworth's categorization of the infant-mother attachment patterns based on the security theory (Bretherton, 1992). Attachment, which is the emotional engagement of infant and mother based on the infant's proximity satisfaction, constitutes the cognitive, affective and behavioral representations of the later interpersonal relationships. First of all, according to Bowlby, an attachment pattern was developed with the attachment figure in four stages. In the first stage, the infant was not able to discriminate the response, second, the infant figured out the primary caregiver and others. Third, a secure based attachment built up between the infant and the primary caregiver as the primary caregiver answered most of the contact needs of the infant, and lastly, had a healthy child-parent relationship with the secure attachment (Alantar & Maner, 2008).

Although there are two needs of infant, physiological and psychological, responding to the psychological expectations has the main role while building up a secure based relationship. Harlow and Zimmermann questioned which need was the primary one in their experiment with rhesus monkeys (1958). In the experiment with a surrogate mother from wire or wood was presented to the rhesus monkeys and one of the surrogate mother was bare wire and the other surrogate mother was covered with cloth. In one condition, the bare wire mother had the milk and the cloth mother didn't have any food. On the other hand, in the second condition, the cloth mother had the milk and the bare wire mother didn't. The results showed that in the first condition, the rhesus monkeys only went to the bare wire mother when they needed

food, but spent their time with the cloth mother. Therefore, the cloth mother was preferred more in both conditions, even when it didn't have a feeding source, milk. Moreover, Harlow's other experiment was required to keep some monkeys away from their mothers but with a nursery-caring mother in social isolation and the other monkeys with their mothers (Harlow, Dodsworth, & Harlow, 1965). At the end, compared with the mother-reared monkeys, the nursery-cared monkeys showed more social deficits, aggressiveness and isolation. Both of the Harlow's experiments supported Bowlby's argument about the significance of psychological proximity between mother and the infant (Harlow & Zimmermann, 1958; Harlow, Dodsworth, & Harlow, 1965).

Attachment security also determines internal working model concept as Bowlby emphasized (1973). The internal working model indicates the degree of fulfillment of child's world exploration and communication needs of infant by the primary care giver (Bowlby, 1973). Thus, the infant began to internalize the child-primary care giver relationship and constituted a framework for the perception of self and future relationships. Therefore, when the infant had a responsive and comforting primary care giver, then the infant constructed a worthy and competent self. On the contrary, if the primary care giver was not available in the need of the infant, the infant perceived the self as unworthy and incompetent.

Moreover, Bowlby considered proximity seeking as an inborn affect regulation device that was devised as a protection from physical and psychological threats and to ease handling distress (1982/1969; 1973; 1988). As the infant's attachment bond comprised, it strengthened the internal working model and affect

regulation strategies at the same time. Afterwards although those strategies could be changed occasionally, as an adult most of the time previously developed strategies would be conserved and used for to the distress evoking situations.

According to Bowlby's conceptualization there were two strategies for affect regulation that were associated with attachment patterns (1982/1969, 1973). The primary attachment strategy was developed by attachment security with the successful integration of affect regulation and gave the sense that the world is a safe place to explore and the others were reliable to be engaged. One's with attachment anxiety and attachment avoidance utilized the secondary strategies in which the worthy of self was doubted and the world considered as a threatening place. The hyperactivating strategy and deactivating strategy were activated by attachment anxiety and attachment avoidance respectively (Mikulincer, Shaver & Pereg, 2003; Lopez & Brennan 2000). When the hyperactivating strategies became activated, the anxiously attached infant felt vigilant and needed to perceive his primary care giver's availability to feel secure. On the other hand, the infant with attachment avoidance tried to avoid from the primary care giver in order to protect himself from the frustration caused by the unavailability of the primary care giver (Mikulincer, Shaver & Pereg, 2003).

Furthermore, based on Bowlby's theoretical findings about infant attachment Ainsworths, Blehar, Waters and Wall (1978) investigated the behavioral differences between infants when their mothers left the room. The securely attached infant showed distress due to mother's separation, yet comforted with the reunion and continue his independent exploration. The anxious infant demonstrated significant

distress when separated from mother and exhibited anger but not comforted with her return. Lastly, the avoidant infant didn't demonstrate any distress without his mother and also didn't seek proximity with her return. As a result, the infant's emotional and proximity seeking reactions demonstrated differences depending on their attachment bond. With the secure attachment the infant was able to predict relations and confident to explore the environment, feel the emotions of fear and anxiety knowing that the mother was always there when the infant return from his discovery (Biringen, 1994; Lopez & Brennan, 2000).

Correspondingly, expanding Ainsworth three-category attachment theory, Hazan and Shaver (1987) suggested that adult romantic relationship attachment was parallel with the infancy attachment. Therefore, the infant–primary care-giver relationship also became a representation for later peer or romantic relationships (Biringen, 1994). Thus, in the form of adult relationships, attachment anxiety was the degree of worry towards the partner's responsiveness and availability. Adults with attachment anxiety were very sensitive to the degree of partner's love and support. When a situation triggers attachment anxiety, the hyperactivating strategy arouses and the needed proximity, love and support tried to be achieved with the lack of confidence, yet feel anger if these resources were not provided (Cassidy & Kobak, 1988; Lopez & Brennan 2000). Furthermore, the desire for distance and self-reliance in interactions and the perception of interdependence and intimacy as a threat were the features of adults with attachment avoidance. In their relationships, they demonstrate discomfort when the partner tries to get in their personal spaces (Lopez & Brennan, 2000; Kaitz & Bar-Haim, 2004). The avoidant-attached adults behaved

according to the deactivating strategies in distress that denied the need for attachment and proximity, avoid closeness and interdependence in relationships.

1.4.1 Attachment and Eating Attitudes

Beginning from the infancy, eating could be considered as one of the secondary attachment strategies and a kind of compulsive behavior for the unresponsiveness and unavailability of the primary care giver (Pearlman, 2005). Alantar and Maner (2008) suggested that infants decreased their anxiety and relax with thumb sucking and eating when they experienced inadequate communication with the caregiver. According to Bruch (1973; 1978) due to the overprotected, intrusive and controlled family environment, the child learnt compliance as a survival tool. However, because of the compliance the child could not be able to develop the ability to recognize basic needs and could not differentiated the feeling hungry or satisfied. Therefore, anorexia nervosa was described as a way of improving covert communication and acquiring autonomy (Bruch, 1973; Bruch, 1978). Thus, link between early attachment disturbances in parent-child relationship and disordered eating in adulthood was supported by many studies (Zachrisson, & Skarderud, 2010; O'Shaugnessy, & Dallos, 2009). The insecure attachment prevalence among women with eating disorders was found between 70% and 100% (Ramaciotti, Sorbello, Pazzagli, Vismara, Mancone, & Pallanti, 2001; Ringer & Crittenden, 2008; Zachrisson & Kulbotten, 2006). Furthermore, specific disordered eating behaviors considered as the direct expressions of the psychological and emotional processes according to their attachment dimensions (O'Shaugnessy, & Dallos, 2009). In their study, Candelori & Ciocca (1998) indicated that attachment avoidance was associated with anorexia, while bulimia was associated with

attachment anxiety. Based on the avoidant attachment, the restricting behavior was a demonstration of distancing from the self, yet the bulimic behavior was an expression of unregulated emotion characterized by the anxious attachment (Cole-Detke & Kobak, 1996; Ringer & Crittenden, 2007; Zachrisson & Kulbatten, 2006). Though the mentioned studies exhibited the link between anxious/avoidant attachment and disordered eating yet it was unclear which specific attachment dimesion was related to which eating disorder symptoms (Elgin & Pritchard, 2006). Thus, besides the unclear casual relationships, various studies searched for the reason, meaning and function of disordered eating.

As an expansion of Bowlby's concept, Orzolek – Kronner investigated the relationship between proximity seeking and development of eating disorders (2002). The inventory of parent, peer attachment and parental attachment questionnaire and proximity seeking questionnaire were used to collect data from 44 participants with eating disorder, 28 clinical controls and 36 non-clinical controls. The reports revealed that since their eating disorder diagnosed, half of the participants began to develop a closer relationship with their mothers. Supporting that report, eating disordered participants exhibited more proximity seeking behaviors compared to rest of the participants. Therefore, disordered eating is a tool for replacing hunger for closeness (Orzolek – Kronner, 2002).

Depending on the significant mother-infant relationship, transgenerational transmission of the mothers' attachment dimension to their daughters was explored (Ward, Ramsay, Turnbull, Steele, Steele, & Treasure, 2001). Adult Attachment Interview was conducted with 20 anorexia patients and 12 of their mothers. Out of

19 insecurely attached anorexia patients, 15 of them had avoidant attachment and out of 10 insecurely attached mothers, 7 of them had avoidant attachment as well. Although a direct association between mother-daughter attachment dimension was not found, the difficulty of emotion processing, low reflective functioning and high idealization were found in both mother and daughters (Ward et al, 2001). Therefore, not only mothers rather all members in the family and the family dynamics contribute developing disordered eating.

Ringer and Crittenden (2007) also examined the family dynamics additionally to the attachment dimensions. Adult Attachment Interview was used with 62 young women with disordered eating symptoms (26 bulimia nervosa, 19 anorexia nervosa, 17 bulimic anorexia). Anxious attachment was detected for all participants. Moreover, the interview suggested lack of resolution of trauma or loss among the mothers and hidden family conflict between the parents. Because of the mothers' did not demonstrate the reason of their sadness, silence or fear about their own trauma, loss or marriage dissatisfaction, their daughters were unaware of their problems, so they attributed their mothers' behaviors to themselves (Ringer, & Crittenden, 2007). As a result, this attribution to the self may contribute the idea of unworthiness of internal working model. Therefore, the risk of developing disordered eating increased.

1.4.1.1 Gender Differences in Attachment and Eating Attitudes

Attachment and its affect on eating attitudes could differ between women and men. Elgin demonstrated that anxious attachment was significantly associated with disordered eating behavior for women but not for men (Elgin & Pritchard, 2006).

Furthermore, although body dissatisfaction was found as a mediator, the study demonstrated that anxious attachment related with disordered eating for women and related with dieting for men (Koskina, & Giovazolias, 2010).

Overall, besides the gender differences, attachment, which is established through the availability and responsiveness of mother, is a significant dimension that determines the perception of self, environment and emotion regulation. Therefore, an unsatisfactory mother-infant relationship precipitated infant to develop attachment insecurity. Consequently, the insecurely attached infant perceived the self as unworthy and environment as threatening and had difficulties in emotion regulation.

1.5 Emotion Regulation

Emotions are dynamic variables in terms of intensity and response that change rapidly in a continuum from positive (happy, joyful) to negative (sad, anxious) (Hilt, Hanson, & Pollak, 2011). Likewise many other attitudes, emotions are so influential on eating attitudes. For instance, it was found that boredom; depression and fatigue increased while fear, pain and tension decreased the food consumption (Mehrabian, 1980). Additionally, although positive emotions increased the tendency to consume healthy foods, negative emotions increased the tendency to consume junk food (Lyman, 1982).

Macht (1999) conducted a study that explored the effects of emotions on eating attitudes. Out of 210 women and men participants, some of them were asked to skip meals in order to create a food deprivation category. Eating attitudes were questioned

while imagining feeling anger, fear, sadness and joy. Eating attitudes divided as four factors, hunger, impulsive eating, sensory eating and hedonic eating. Hunger described as decreases or increases of the desire to eat, feeling of hunger and thinking of food. Impulsive eating referred to fast and careless eating. Sensory eating illustrated eating with intense flavors (salty or acidic) that are found in snack foods. Lastly, hedonic eating reflected the tendency to eat because the food is pleasant or healthy (Macht, 1999). The results showed that hunger was found higher while feeling anger and joy but not feeling fear or sadness. Anger was more influential on impulsive and sensory eating than fear and sadness. Joy was the least emotion that was effective on impulsive and sensory eating but the most influential one on hedonic eating (Macht, 1999).

Additional study done by Macht (2008) searched further about the effect of emotions on eating. Contrary to the previous one, this study also considers individual's characteristics and emotion features. According to the factors as antecedents and effects of emotions, eating attitude converted into five dimensions. First, emotional control of food choice; second, emotional suppression of food intake; third, impairment of cognitive eating controls; fourth, eating to regulate emotions; fifth, emotion congruent modulation of eating. Based on emotion features and eating attitudes, the changes in eating could be because of interference (suppression of food intake; impairment of cognitive eating controls) and congruence with modulation of eating and the regulatory process (emotional control of food choice, eating regulates emotions) (Macht, 2008).

Despite the influence of emotions on eating seems inevitable, the appropriate regulation of those emotions depends on the self as well. As the attachment style enables infant to relate with the world through mother, emotions and regulations are learnt from the mother-infant relationship (Hilt, Hanson, & Pollak, 2011). Compared to the securely attached children, children with unsecure attachment whose parents punish or ignore their emotions had more difficulty regulating their emotions because they did not know how to sooth themselves and how to engage others' emotions. To describe, emotion regulation developed by attachment is the mechanism to cope and intervene appropriately to the arising emotion evoked by a situation (Koole, 2009; Cole, Michel, & Teti, 1994). For instance, choosing to be calm down during a fight is a way of emotion regulation.

Emotion regulation was consisted of multiple processes. The first process was to read and understand emotional signals; second, to sort and categorize the emotions signals in order to construct an appropriate response; and third, to enact an appropriate behavior response (Hilt, Hanson, & Pollak, 2011). The aim of the emotion regulation is to decrease the intensity and time of the emotion, to ease the transmission between emotions and to gain relief (Hilt, Hanson, & Pollak, 2011). Folkman (1984) mentioned two ways of emotion regulation strategies. One of them process and the other one relational oriented. The individuals utilized process oriented strategy had a tendency to solve or decrease the negative emotion-evoking situation. On the other hand, individuals who use relational orientation engaged more to acceptance or avoidance strategies. In other words, the emotional relief was gained by solving the problem for the process-oriented individuals while the emotional relief itself was enough for the relational oriented individuals. However, avoidance

was not an efficient strategy to solve problems, thus, relational oriented individuals had to encounter more problems in long run (Folkman, 1984).

The adaptive and efficient problem solving considered as active problem solving, search for support, cognitive reanalyzing. However, denials, avoidance, aggressiveness, rumination, inability to express emotions were dysfunctional and inefficient ways for problem solving (Arslan, 2010).

1.5.1 Emotion Regulation Difficulty and Eating Attitudes

The emotion regulation difficulty occurs when the emotions are experienced so intense and overwhelming and the strategies could not function properly (Hilt, Hanson, & Pollak, 2011). According to Gratz and Roemer (2004), lack of awareness about emotions, inability to recognize and accept emotions, having difficulties with impulse control while experiencing negative emotions and inability to use functional emotion regulation strategies are the features of emotion regulation difficulties. The emotion regulation difficulty is a significant problem for the psychological disorders, eating disorders. Emotions were inhibited and repressed and expressed in the form of eating related emotions and behaviors. Emotions aroused such as fear of gaining weight, irritability, depression and anxiety; behavioral reactions exhibited such as social withdrawal, binge eating and vomiting. (Cole, & Hall, 2001).

Binge eating is one of the mostly searched eating disorder cluster while understanding emotion regulation. The study done by Deaver, Miltenberger, Smyth, Meidinger, & Crosby investigated the affect change during the binge episodes (2003). Participants' level of pleasantness was recorded at 2 minutes intervals before,

during and after binge eating and regular meals. The negative emotions that were experienced before the binge-eating episode decreased during the binge-eating episode. However, after binge eating episode negative emotions' intensity increased more than before (Deaver et al., 2003). People also tended to binge eat when they felt intensive negative emotions, yet during the regular meals their affect was assessed as normal (Deaver et al., 2003). Therefore, eating functions as a negative reinforcement that created temporary relief from the negative affect.

Furthermore, the association between binge eating, over-evaluation of weight and shape, food restriction and types of emotion regulation difficulties was assessed (Whiteside et al., 2007). The results showed that the emotion regulation difficulty contributes in the development of binge eating, food restriction and over-evaluation of weight and shape. In terms of specific strategies of emotion regulation, binge eaters had difficulty in identifying and making sense of emotional states and inability accessing effective and functional emotion regulation strategies (Whiteside et al., 2007).

Consequently, literature pointed out that eating is a way of emotion regulation. Therefore, the overwhelming emotions could affect eating behaviors and eating attitudes and the eating behavior played the role of the negative reinforce.

1.5.1.1 Gender Differences in Emotion Regulation and Eating Attitudes

Eating considered as a substitute strategy for regulating emotions. Yet, different emotional difficulties and regulating strategies were detected between women and men (Ty, & Francis, 2003; Weinberg, & Klonsky, 2009). As Ty and Francis (2013)

suggested, having difficulty in accepting emotions, finding goal oriented behavior and being impulsive found more in women with disordered eating attitudes. Likewise, it was found that women with disordered eating had more difficulties than men in emotion regulation strategies such as emotional clarity, ability to engage in goal-oriented behavior and strategies for emotion regulation (Lafrance Robinson, Kosmerly, Mansfield-Green, & Lafrance, 2014).

Overall, women and men show different patterns of emotion regulation strategies depending on their eating attitudes.

1.6 Eating Attitudes, Attachment and Emotion Regulation Relationship

Attachment influenced the development of emotion regulation strategies that are utilized for the future interactions between individuals (Hilt, Hanson, & Pollak, 2011). Secure attachment was developed through availability and responsiveness of the mother towards infant's need that the mother and the infant both had the same emotional connection. Therefore, it could be suggested that the infant and the mother's emotional states were attuned to each other. On the contrary, misattuned emotions of the infant and mother precipitated attachment anxiety and attachment avoidance through infants' chronically frustrating experiences (Pearlman, 2005). As a result of these positive and satisfying or negative and frustrating interactions with the mother, the infant began to build up emotion regulation strategies (Mikulincer, Shaver & Pereg, 2003). The security-based strategies were developed by the attachment security that included "*optimistic beliefs about distress management, a sense of trust of others' goodwill and a sense of self-efficacy in dealing with threats*" (Mikulincer, Shaver & Pereg, 2003). On the other hand, individuals with attachment

anxiety or attachment avoidance were tended to use secondary attachment strategies, hyperactivating and deactivating strategies for the emotion regulation respectively. With the hyperactivating strategies, negative emotions were attended and negative thoughts were ruminated; and the aversive emotional states were inhibited and the negative experiences blocked from acknowledgement with the deactivating strategies (Mikulincer, Shaver, & Pereg, 2003).

The unsecurely attached individuals who employed secondary attachment strategies had difficulty in emotion regulation. Thus, Pearlman (2005) demonstrated that thumb sucking or eating were the ways of alleviating the unregulated levels of negative emotions for infants and adults respectively. Moreover, women engaged in disordered eating behavior to regulate their emotions and escaped from their negative emotions. (Harrison, Sullivan, Tchanturia, & Treasure, 2009) Therefore, while investigating disordered eating the interacting relationship between attachment and emotion regulation should be considered.

The relationship between negative emotions, attachment insecurity and eating disorders was investigated by Tasca, Kowal, Balfour, Ritchie, Virley, & Bissada (2006). It was hypothesized that the eating disorder symptoms would be influenced by the attachment insecurity. Data collected from two hundred and sixty eight eating disordered women and assessed according to their attachment insecurity, BMI, perceived pressure to diet, body dissatisfaction, restrained eating and negative emotions. The findings supported attachment insecurity was related to body dissatisfaction and negative emotions for women with eating disorders (Tasca et al., 2006).

Kobak and Sceery (1988) explored the relationship between attachment dimension, emotion regulation and representations of self and others. It was found that the group with secure attachment was more ego-resilient, less anxious, less hostile by peers and reported less distress and high levels of social support. The group with avoidant attachment was low on ego-resilience and higher on hostility by peers and reported more distant relationship, high loneliness, low levels of social support from family. Lastly, the group with anxious attachment was less ego-resilient, more anxious by peers and reported high levels of personal distress and higher levels of social support from family compared to the avoidant attached participants.

Lastly, Ty and Francis (2013) investigated the intermediary relationship between emotion regulation and eating disorders in the attachment framework. First, it was found that anxious and avoidant attachment was positively associated with greater emotion regulation difficulty. Additionally, emotion regulation difficulty had a mediator role in the relationship between insecure attachment and eating disorders (Ty, & Francis, 2013).

Overall, the literature mentioned that insecure attachment could be significantly associated with emotion regulation difficulty that could also help to understand the role and development of disordered eating attitudes.

1.7 Research Question

The current study was designed to inquire eating attitude development through attachment and emotion regulation. As previous literature noted the prevalence and incidence rates of eating disorders have been increasing since last decades (Kendell et al., 1973; Whitetaker et al., 1990; Klein & Walsh, 2003). Therefore, there was a necessity to search eating attitudes that range between healthy and disordered for a non-clinical group.

Furthermore, attachment and emotion regulation were widely investigated precursors for eating attitudes (Ozolek-Kronner, 2002; Deaver et al., 2003; Alantar ve Maner, 2008; Zachrisson, & Skarderud, 2010; O'Shaugnessy, & Dallos, 2009; Ramaciotti et al, 2001; Ringer & Crittenden, 2008; Zachrisson & Kulbotten, 2006). Yet, although attachment and emotion regulation relationship with eating attitudes searched independently, there were few studies that explore their dual relationship with eating attitudes (Ringer & Crittenden, 2007; Whiteside et al., 2007).

Lastly, as Hilt, Hanson & Pollak argued emotion regulation was also developed through attachment (2011). With secure attachment, the infant was able to improve adaptive emotion regulation strategies, on the contrary, poor emotion regulation strategies developed by unsecure attachment leaded to use different coping ways such as eating to sooth self. Yet, the literature was not adequate to illustrate the developmental pathways of eating attitudes by taking the attachment and emotion regulation relationship into account (Tasca et al., 2009).

Main purpose of the study was to investigate contribution of attachment styles and emotion regulation in the prediction of eating attitudes. Consequently, following research questions were explored.

(1) Do women and men differ in terms of eating attitudes, attachment and emotion regulation?

(2) Do attachment and emotion regulation have a relationship with eating attitudes?

(3) Do attachment and emotion regulation predict eating attitudes?

1.8 Hypotheses

The following hypotheses will be tested with Eating Attitude Test, Experiences in Close Relationships Scale and Difficulties in Emotion Regulation Scale. Considering the sample characteristics and literature review; it was hypothesized that

1) Women demonstrate more disordered eating attitudes, anxious attachment and emotion regulation difficulty than men.
2) Anxious attachment style is positively correlated with disordered eating attitudes.
3) Lack of clarity of emotional responses, nonacceptance of emotional responses, limited access to effective strategies, difficulties in controlling impulses and difficulties in engaging goal directed behavior are positively and lack of awareness is negatively correlated with disordered eating attitudes.

4) Anxious attachment style, lack of awareness, lack of clarity of emotional responses, nonacceptance of emotional responses, limited access to effective strategies, difficulties in controlling impulses when experiencing negative affect and difficulties in engaging goal directed behavior are the predictors of disordered eating attitudes.

CHAPTER 2

METHOD

2.1 Population and Sample

The participants were constituted private and public college students living in Istanbul through convenient sampling. For the randomization, data were collected from two private colleges, Koç University and Bahçeşehir University and two public colleges, Boğaziçi University and Istanbul Technical University with paying attention to the equality of female and male participants. The sample recruited by asking to fill a package of questionnaires including demographic form, Eating Attitude Questionnaire, Experiences in Close Relationships Scale and Difficulties in Emotion Regulation Scale during their spare time between lectures.

The analysis was performed with the information gathered from 294 participants, 147 female and 147 male. The sample's demographic characteristics were summarized in the Table 1.

Table 1: Social-demographic characteristics of participants

		N	Age Range	Age Mean
Public College		143	18-31	21.83
	Female	69	18-31	21.66
	Male	74	19-30	22.00
Private College		151	18-33	22.00
	Female	78	18-33	21.79
	Male	73	19-29	22.21
Total		294	18-33	21.91

Additionally, between 151 private and 143 public college students, 86 of them were studying in 2nd grade with 29.3%. 62 (21.1%), 49 (16.7%), 41 (13.9%), 26 (8.8%) and 4 (1.4) of them were studying in 3rd, 4th, 1st grade, prep and master and doctorate respectively. Participants' major's varied in a broad range for the homogeneity of the sample. Mining geology engineering, chemical engineering, industrial engineering, biomedical, business administration management, media and visual arts, photography, sociology, psychology were some of the majors.

Participants' age was between 18 and 33 and most of the participants were 20 years old (M = 21.92 SD = 2.28). Among all participants, 230 (78%) participants' socio-economic status was moderate. In terms of living areas, 112 (38.1%) of the participants were living with their parents in parents' house, 77 (26.2%) of them were living with their friends in dorms, 65 (22.1%) of them were living with in a house with their friends, 24 (8.2%) of them were living alone in a house, 9 (3.1%) of them were living alone in dorm, 5 of them were living in a house with their relatives, 2 (0.6%) of them were living with their friends and family in a house.

In terms of Body Mass Index, there were 200 (68.8%) normal weight participants, 47 (16%) overweight participants, 34 (11.6%) underweight participants and 13 (4.4%) obese participants. Among all participants, 125 (42.5%) of them considered their childhood weight as normal. Among 294 participants only 142 (48.3%) of them consider their weight as normal and 186 (63.3%) of them declared their wish to loose weight. Additionally, 146 (49.7%) of the participants stated that they had not ever dieted in their lives and 245 (83.3%) of the participants were not dieting at the time completing the questionnaire. Lastly, 185 (62.9%) of the participants were not doing exercise and among 109 (37.1%) participants doing exercise 85 (28.9%) of them were exercising several days in a week. Table 2 explains the weight change according to gender and BMI.

Table 2: Number of participants categorized based on gender, BMI and weight change

		Underweight	Normal Weight	Overweight	Obese
Female					
	Lose Weight	11	87	13	3
	Gain Weight	8	4		
	No Change	11	10		
Total		30	101		3
Male					
	Lose Weight		42	30	10
	Gain Weight	4	32	2	
	No Change		25	2	
Total		4	99	34	10

2.2 Measurement Tools

Each participant completed a package of questionnaires included the demographic form. The package included Eating Attitudes Test-40 (Garner ve Garfinkel, 1979), Experiences in Close Relationships Inventory (Brennan, Clark, & Shaver, 1998) and Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004).

2.2.1 Demographic Form

Demographic form (see Appendix B) was consisted of three parts in terms of the content of information. In the first part, gender, age, weight, height, education, socio-economic status, living place, family information was asked to the participants. Questions about the perceived current weight, perceived childhood weight, aim of the dieting were filled in the second part and in the third part, questions about the effect of emotions on eating attitudes and exercising habits were completed.

2.2.2 Eating Attitudes Test-40 (EAT-40)

Eating Attitudes Test, developed by Garner and Garfinkel (1979), aims to assess the level of disordered eating attitude and identify the traits of anorexia nervosa and bulimia nervosa. The questionnaire was 6 points Likert type scale with the choices of always, frequently, often, sometimes, rarely and never. The total score was gained by adding all the scores and the cut off score was determined as 30 points. Yet, besides the cut off score, the higher obtained points were indicating the higher frequency of disordered eating attitude. The internal consistency was found as .94 (Garner and Garfinkel, 1979).

Test retest reliability and internal consistency analysis done by Savaşır and Erol for Turkish version (1989). The discrepancy between disordered eating attitude and normal eating attitudes were clear for Turkish version of the test. Test retest reliability was found as .65 and Cronbach alpha was found as .70 (Savaşır & Erol, 1989). The cut off score was not determined for Turkish version. Turkish version of Eating Attitudes Test could be found in Appendix C.

2.2.3 Experiences in Close Relationships Inventory

Experiences in Close Relationships Inventory consisted of 36 questions that aim to explore the adult attachment styles (Brennan, Clark, & Shaver, 1998). Based on attachment theory, the questionnaire inquires the participants attachment dimension, avoidance or anxious. The questionnaire was 7 point Likert scale that 1 point was given for strongly disagree and 7 points was given for strongly agree. The avoidance and anxious scores were calculated separately and the higher score determines the participants' attachment dimension. The odd total score referred to the avoidance attachment style whereas the even total score indicated the anxious attachment style.

Sümer and Güngör (2000) assessed the psychometric properties of Turkish version of Experiences in Close Relationships Inventory. The internal consistency was found as .84 and .81 for avoidance and anxious attachment styles respectively. The reliability scores were .86 for avoidance and .90 for anxious attachment styles. Additionally, two dimension was explained the 38% of the total variance (Sümer, & Güngör, 2000). Turkish version of Experiences in Close Relationships Inventory could be found in Appendix D.

2.2.4 Difficulties in Emotion Regulation Scale

Difficulties in Emotion Regulation Scale, developed by Gratz and Roemer (2004), is a 36 item scale aim to evaluate the level of difficulty while regulating emotions. In 6 dimensions, questions evaluate lack of awareness (Awareness), lack of clarity of emotional responses (Clarity), nonacceptance of emotional responses (Nonacceptance), limited access to effective strategies (Strategies), difficulties in controlling impulses when experiencing negative affect (Impulse) and difficulties in engaging goal directed behavior when experiencing negative affect (Goals). The questionnaire was designed as a 5 point Likert scale ranging from 5 points for almost always to 1 point for almost never. The higher score indicates the higher difficulty according to the dimension.

The internal consistency was .93 for total scale and ranging from .80 to .89 for each subscale (Gratz, & Roemer, 2004). Furthermore, test retest reliability was found as .88. Turkish version of Difficulties in Emotion Regulation Scale developed by Rugancı (2008). The internal consistency was found as .94 for the total score and ranging from .90 to .75 for the subscales (Rugancı & Gençöz, 2010). Turkish version of Difficulties in Emotion Regulation Scale could be found in Appendix E.

2.3 Procedure

Data collected by asking participants to complete the package of questionnaires in their spare time in university. For the beginning, participants read the Informed Consent Form and decided to join the study. The Informed Consent

Form can be found in Appendix A. Afterwards, they completed the demographic form, Eating Attitudes Test-40 (EAT-40), Experiences in Close Relationships Inventory (ECR) and Difficulties in Emotion Regulation Scale (DERS). There were 137 questions in total and completion lasted approximately 15-20 minutes. Data collection was conducted from April to June, 2014.

2.4 Data Analysis

The analysis was done in several steps. First, based on the demographic information, comparison and correlation analyses investigated through one-way ANOVA and Correlation. Second, the descriptive statistics of the dependent, eating attitudes and independent variables, attachment style and emotion regulation difficulties, were explored. Third, correlations run between eating attitudes, attachment style and emotion regulation difficulties to investigate their relationship. Fourth, linear regression analysis were run to explore the prediction probability between eating attitudes, attachment styles and emotion regulation difficulties.

CHAPTER 3

RESULTS

3.1 Descriptive Analyses

The demographic form consisted of various questions to understand the sample's characteristic. Gender differences, EAT-40, ECT and DERS characteristics for the sample were explored.

3.1.1 Gender

A series of one-way ANOVA were conducted to understand the gender differences in terms of eating attitudes, avoidance and anxious attachment and subscales of emotion regulation difficulties. Results were presented at Table 3.

Table 3: Gender differences in terms of eating attitudes, attachment and subscales of emotion regulation difficulties.

	Female		Male		
	M	SD	M	SD	*F*
EAT	18.68	8.39	15.63	7.58	10.72**
ECR-Anxious	66.48	17.50	61.39	1.43	5.15*
DERS-Clarity	13.97	2.44	13.17	2.44	8.05*
DERS-Strategies	20.80	6.20	18.86	6.54	6.79*
DERS-Goals	16.40	4.68	15.02	4.55	6.59*

Notes: EAT = Eating Attitude Test , ECR = Experiences in Close Relationships Inventory, DERS = Difficulties in Close Relationships Scale
**p < .01, *p < .05

3.1.2 Eating Attitudes Test

Eating Attitudes Test aimed to assess the disordered eating behavior and the tendency to develop eating disorders. 30 points expresses the disordered eating attitude in the original test. However, Turkish version of the test did not have a cut off point and higher score indicates higher disordered attitude in eating behavior. In the current data, the minimum score was 3, the maximum score was 49, the mean was 17 and the standard deviation was 8.

3.1.3 Experiences in Close Relationships Inventory

Experiences in Close Relationships Inventory aimed to determine one's attachment style as anxious or avoidant. The participants' attachment style was categorized as comparing the two attachment style scores that the higher score indicates the attachment style. In the current data, for anxious attachment style, the minimum score was 22, the maximum score was 111, the mean was 63 and the standard deviation was 19. For avoidant attachment style, the minimum score was 20, the maximum score was 114, the mean was 57 and the standard deviation was 18.

3.1.4 Difficulties in Emotion Regulation Scale

Difficulties in Emotion Regulation Scale aimed to explore the aspect of difficulty with six subscale, awareness, clarity, nonacceptance, strategies, impulse and goals. The higher total score exhibits the more difficulty in emotion regulation in general and the high score in a specific subscale indicates the specific difficulty in emotion regulation. In the current data, for the total emotion regulation difficulty, the minimum score was 42, the highest score was 143, the mean was 91 and the standard

deviation was 20. The minimum, maximum, mean scores and standard deviation of the key variables were presented in Table 4.

Table 4: Descriptive statistics of key variables

	N	Mini	Max	Mean	SD
EAT	294	3.00	49.00	17.15	8.12
ECR-Anxious	294	22.00	111.00	63.90	19.06
ECR-Avoidance	294	20.00	114.00	57.78	18.37
DERS-Awareness	294	6.00	26.00	14.66	3.97
DERS-Clarity	294	7.00	19.00	13.57	2.47
DERS-Nonacceptance	294	6.00	30.00	13.55	5.45
DERS-Strategies	294	8.00	36.00	19.83	6.43
DERS-Impulse	294	6.00	29.00	14.58	5.17
DERS-Goals	294	5.00	25.00	15.71	4.66

Notes: EAT = Eating Attitude Test, ECR = Experiences in Close Relationships Inventory, DERS = Difficulties in Emotion Regulation Scale

3.2. Pearson Correlations among Eating Attitudes, Attachment and Emotion Regulation

The correlation analysis investigated the relationship between eating attitudes, attachment styles and emotion regulation difficulties. The results supported the hypothesis that eating attitude scores were significantly positively correlated with anxious attachment style ($r(294) = .12$, $p < .05$). In addition to this, the second hypothesis was partially supported that, eating attitudes were significantly positively correlated with emotion regulation difficulty subscales, Goals, $r(294) = .14$, $p < .05$; and Strategies, $r(294) = .15$, $p < .01$; negatively correlated with Awareness, $r(294) = -.13$, $p < .05$.

In terms of attachment styles, anxious attachment style was significantly positively correlated with clarity, $r(294) = .22$, $p < .001$; nonacceptance, $r(294) = .44$, $p < .001$; strategies, $r(294) = .53$, $p < .001$; impulse, $r(294) = .44$, $p < .001$; and goals, $r(294) = .42$, $p < .001$. Moreover, avoidance attachment style was correlated with clarity, $r(294) = .27$, $p < .001$; nonacceptance, $r(294) = .32$, $p < .001$ and strategies, $r(294) = .16$, $p < .001$.

Lastly, subscales of emotion regulation difficulties' correlations were also pointed out with the previous findings from eating attitudes and attachment styles. The findings were presented in Table 5.

Table 5. Correlations of the key variables

	1	2	3	4	5	6	7	8	9
1 EAT									
2 ECR-Anxious	.12*								
3 ECR-Avoidance		.11*							
4 DERS-Nonacceptance		.44**	.32**						
5 DERS-Goals	.14*	.42**		.41**					
6 DERS-Impulse		.44**		.53**	.56**				
7 DERS-Awareness	-.13*				-.13*				
8 DERS-Strategies	.15**	.53**	.16**	.60**	.72**	.67**			
9 DERS-Clarity		.22**	.27**	.32**	.26**	.39**	.31**	.40**	

Notes: EAT = Eating Attitude Test , ECR = Experiences in Close Relationships Inventory, DERS = Difficulties in Close Relationships Scale
**p < .01, *p < .05

3.3. Regression

Based on the significant correlation results, hierarchical multiple regression was performed utilizing eating attitudes as the dependent variable. Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. Anxious attachment was entered at stage one of the regression to control for attachment dimension. Awareness, strategies and goals were entered on the stage two. The hierarchical multiple regression analysis revealed that at stage one, anxious attachment contributed significantly to the regression model, $F(1,292) = 4.90$, $p < .05$ and accounted for 17% of the variation in eating attitudes. Introducing the awareness, strategies and goals variables explained 44% of variation in eating attitudes and this change in *R2* was significant, $F(4,289) = 3.3$, $p < .05$. Among the four variables, the model as a whole was significant $F(4,289) = 3.43$, $p < .05$. When the anxious attachment influence on eating attitudes controlled, awareness found as the strongest predictor while explaining eating attitudes. Therefore, independent from the attachment, awareness could predict eating attitudes ($\beta = -.12$), $t = -2.14$, $p < .05$ (Table 6).

Table 6. Hierarchical multiple regression model of eating attitudes

	R	R^2	R^2 Change	B	*SE*	β	*t*
Step 1	.128	.017*	.017*				
ECR-Anxious				.055	.025	.128*	2.21
Step 2	.210	.044*	.028*				
ECR-Anxious				.026	.029	.060	.885
DERS-Awareness				-.257	.120	-.126*	1.04

Notes: ECR = Experiences in Close Relationships Inventory, DERS = Difficulties in Close Relationships Scale. **p < .01, *p < .05

CHAPTER 4

DISCUSSION

The aim of the study is to investigate the relationship between eating attitudes, attachment and emotion regulation and additionally explore the predictor role of attachment and emotion regulation while understanding eating attitudes.

4.1 Gender Differences based on Eating Attitudes, Attachment and Emotion Regulation

First of all, descriptive analysis results exhibited the characteristics of the current sample. The differences in eating attitudes, attachment and emotion regulation were explored between genders. As Berg, Frazier and Sherr (2009) found the current results supported that women and men had different eating attitudes and women had more disordered eating attitudes than men. In terms of attachment, despite of not showing any significant differences in avoidance attachment, women were found more anxiously attached compared to men. This result was also consistent with the Elgin's finding that anxious attachment was significantly associated with disordered eating behavior for women (Elgin, 2006). In addition to this, women had more difficulties in regulating their emotions than men.

As literature suggested (Ty & Francis, 2013), the current study results also revealed the differences between women and men in emotion regulation difficulties. It was found that women experienced more difficulties in finding goal directed behavior than men while encountering negative emotions. Additionally, women had more difficulties in finding emotion regulation strategies than men in their emotional reactions. Lastly, men were found to understand the emotional reactions more clearly than women. Thus, women with disordered eating attitudes were more inclined to be unaware, uncertain and non-accepting of their emotions, unable to focus on goal oriented behaviors, impulsive and unable to use self-soothing strategies while experiencing negative emotions (Ty & Francis, 2013).

4.2 Correlation between Eating Attitudes, Attachment and Emotion Regulation

The correlation analysis between eating attitudes, attachment style and emotion regulation difficulties demonstrated that participants with anxious attachment style had more tendencies to have disordered eating attitudes. As the current sample's disordered eating could be bulimia nervosa or binge eating, Candelori and Ciocca's (1998) finding supported the current finding that anxious attachment was more found in individuals with bulimia symptoms. Participants with anxious attachment were having more difficulty in emotional acceptance, clarity, impulse control, finding adaptive strategies and goal directed behavior. Kobak & Sceery (1988) also suggested that the anxious attachment was associated with difficulty in coping with dense positive and negative emotions. Therefore, the unregulated emotions would increase the anxiety and would be reflected through their eating attitudes such as bingeing, purging or restricting (Ty & Francis, 2013). Furthermore, in spite of the fact that participants with avoidant attachment were

having difficulties in accepting their emotions, understanding emotional reactions clearly and finding adaptive emotion regulation strategies, their eating attitudes were not significantly alter. These findings could be suggested that participants with avoidant attachment cut off their emotions that in turn not affect eating attitudes (Kobak & Sceery, 1988). Moreover, in terms of emotion regulation, as the literature also supported the results that difficulty in identifying the emotional state and limited access to emotion regulation strategies increase the disordered eating but having difficulty in being aware of emotions decrease eating behavior (Whiteside et al, 2007). Additionally, it was demonstrated that difficulty in assessing emotional clarity, ability to use adaptive strategies and goal directed behavior were associated with disordered eating attitudes (Robinson, Kosmerly, Mansfield-Green, & Lafrance Glenys, 2014). Consistently, the present study also found that participants having more difficulties in being aware of emotions, regulating emotional strategies and finding goal oriented behavior were more inclined to have disordered eating attitudes.

4.3 Predictor Role of Attachment and Emotion Regulation for Eating Attitudes

Based on the correlation results, the further investigation was performed to estimate the predictors of eating attitudes as anxious attachment; awareness, strategies and goals subscales of the emotion regulation were included to the analysis. As expected, anxious attachment was found as a significant predictor with explaining seventeen percent of variance in eating attitudes. Moreover, with the emotion regulation, when the predictor role of anxious attachment controlled, awareness explained forty four percent of variance in eating attitudes. This finding was consistent with Deaver et al.'s results (2003) that their study demonstrated

eating is a way of emotion regulation by itself while encountering negative emotions. Therefore, it could be suggested that when eating compensates the negative emotions the needs of finding goal-oriented behavior and finding strategies were eliminated. Thus, among emotion regulation difficulties, being aware of the emotion is the first step that significantly affects and also predicts eating behavior. Therefore, it could be derived that the increase in emotional awareness difficulty decreases the disordered eating attitudes. To conclude, it could be implied that as emotions were very influential on eating attitudes (Macht, 1999; 2008), not being aware of emotions decreased their impact on eating attitudes and conversely increased awareness about emotional reactions had a significant negative impact on eating attitudes.

4.4 Clinical Implications

This study contributed to the clinical area by investigating non-clinical sample with disordered eating attitudes. In addition to this, although studies investigating the relationship between attachment and eating attitudes, emotion regulation and eating attitudes, few studies explored eating attitudes' relation and predictors with attachment and emotion regulation difficulties. The results showed that anxious attachment, difficulty in being aware of emotions awareness, finding adaptive strategies and goal oriented behavior are the related areas that could be worked on with the individuals disordered eating attitudes during therapeutic treatment. Additionally, emotional awareness should be the first area to begin with that the individuals unaware of their emotions reflect their emotions to eating behaviors. Therefore, understanding, evaluating and accepting emotions are the significant topics for treatment.

4.5 Limitations

The study was limited because of the characteristics of the sample. Moreover, the data should be collected in a more standardized setting to access more accurate results. As the assessment tools, Eating Attitudes Test could be considered as an old test but the only test that could be used for Turkish sample. Yet, the specific type of disordered eating attitude was not detected and may complicate the interpretations of the relationships and predictions of eating attitudes.

4.6 Further Research

For the further studies, the setting should be standardized more. Additionally, a more recent test should be standardized for Turkish sample and eating attitude should be investigated with that test which gives more information about eating attitudes. Lastly, attachment's and emotion regulation difficulties' mediation role should be investigated more to understand the relationship accurately.

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APPENDICES

APPENDIX A: INFORMED CONSENT FORM

Sayın Katılımcı,

Bu çalışma, Bahçeşehir Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Psk. Rakel Duenyas tarafından Dr. Serkan Özgün danışmanlığında, üniversite öğrencilerinin bağlanma, duygu regülasyonu ve yeme tutumu arasındaki ilişkiyi incelenmek amacıyla, yüksek lisans tezi kapsamında yürütülmektedir. Sizden, bu amaçla hazırlanmış olan anketimizi doldurmanızı rica ediyoruz.

Anket genel olarak, kişisel rahatsızlık verecek sorular içermemektedir. Ancak, katılım sırasında herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, cevaplamayı istediğiniz an bırakmakta serbestsiniz. Çalışmadan elde edilen bilgiler yalnızca bilimsel amaçlarla kullanılacaktır ve çalışmaya katılan kişilerin cevapları gizli tutulacaktır.

Çalışma hakkında daha fazla bilgi almak için Psk. Rakel Duenyas (yemetutumu@gmail.com) ile iletişim kurabilirsiniz.

Katılımınız için şimdiden teşekkür ederiz!

Bu çalışmaya tamamen gönüllü olarak katılıyorum.

1. Evet
2. Hayır

APPENDIX B: DEMOGRAPHIC FORM

1. Yaşınız:
2. Cinsiyetiniz: a. Kadın b. Erkek
3. Boyunuz:
4. Kilonuz:
5. İdeal Kilonuz (olmak istediğiniz kilo):
6. Eğitim: a. Lisans b. Lisansüstü
7. Okumakta olduğunuz fakülte/ bölüm/ sınıf:
8. Şu an nerede ve kimlerle yaşıyorsunuz?
    a. Evde, tek başıma
    b. Evde, arkadaşlarımla
    c. Evde, ailemle
    d. Evde, akrabalarımla
    e. Yurtta, tek başıma
    f. Yurtta, arkadaşlarımla
    g. Diğer:
9. Ailenizin gelir durumunu nasıl değerlendirirsiniz?
    a. Alt sosyo-ekonomik düzey
    b. Orta sosyo-ekonomik düzey
    c. Üst sosyo ekonomik düzey
10. Anne ve babanız hayatta mı?

    Anne : a. Evet b. Hayır
    Baba: a. Evet b. Hayır

11. Anne ve babanızın medeni durumu:

    Anne: a. Evli b. Boşanmış c. Ayrı yaşıyor d. Dul e. Diğer
    Baba: a. Evli b. Boşanmış c. Ayrı yaşıyor d. Dul e. Diğer

12. Hayatınızda hiç romantik bir ilişki yaşadınız mı? a. Evet b. Hayır

13. Medeni haliniz: a. Bekar, ilişkisi yok b. Bekar, ilişkisi var

c. Nişanlı d. Evli e. Boşanmış f. Diğer:

14. Çocukluğunuzu düşündüğünüzde kilonuzu nasıl değerlendirirsiniz?

a. Zayıf
b. Normal
c. Hafif Kilolu
d. Şişman
e. Aşırı Şişman

15. Diyet yapmakla ilgili aşağıdaki cümlelerden size en uygun olanını işaretleyiniz.

a. Bugüne kadar hemen hemen hiç diyet yapmadım. (18. Soruya geçiniz.)
b. Nadiren diyet yaparım.
c. Sık sık diyet yaparım.
d. Devamlı diyet yaparım.

16. Yaptığınız diyeti hangi amaçla yaptınız?

a. Sağlık problemi dolayısıyla zorunlu
b. İdeal kilomu korumak için
c. Kilo vermek için

17. İlk diyet yaptığınızda kaç yaşındaydınız?

18. Şu anda diyet yapıyor musunuz? a. Evet b. Hayır

19. Şu anki kilonuzu nasıl buluyorsunuz?

a. Zayıf
b. Normal
c. Hafif Kilolu
d. Şişman
e. Aşırı Şişman

20. Duygularınızda büyük değişime neden olacak bir olay/durum yaşadığınızda iştahınız…
a. Etkilenmez. (22. Soruya devam ediniz.)
b. Azalır.
c. Artar.

Duygunuz	Daha *Fazla* Yerim	Daha *Az* Yerim
Mutluluk		
Üzüntü / Yas		
Kızgınlık		
Kaygı		
Korku		
Utanç		
Suçluluk		
Kıskançlık		
Depresif öz-eleştirel hal		

21. Aşağıdaki duygulardan hangilerini daha yoğun hissettiğinizde daha fazla/az yemek yediğinizi fark edersiniz? (1'den fazla seçeneği işaretleyebilirsiniz.)

22. Son 6 ay içerisinde yeme tutumunuzu etkileyecek bir durum yaşadınız mı? (Hamilelik, hastalık vb.) a. Evet b. Hayır

23. Son 6 aydaki yeme düzeninizi düşününce sizin için uygun olanları işaretleyin. (1'den fazla seçenek işaretleyebilirsiniz.)
    a. Birçok kişiye göre normalden çok fazla olarak değerlendirilebilinecek ölçüde yemek yedim.
    b. Sık sık yemek yemeyi kontrol edemeyeceğimi ve duramayacağımı hissettim.
    c. Normalden çok daha hızlı yedim.
    d. Rahatsız edici bir biçimde doyana kadar yedim.
    e. Fiziksel olarak açlık hissetmezken büyük miktarlarda yemek yedim.
    f. Ne kadar yediğim konusunda utanma nedeniyle yalnız başıma yedim.
    g. Aşırı yeme sonrası kendinden nefret etme, kendini suçlu ya da depresif hissettim

24. Düzenli olarak spor yapar mısınız? a. Evet b. Hayır

25. *Yanıtınız evet ise:* Ne sıklıkta spor yapıyorsunuz?
    a. Her gün / Neredeyse her gün
    b. Haftada birkaç kez (Sayısınız belirtiniz: ……)
    c. Haftada bir kez
    d. Ayda birkaç kez (Sayısını belirtiniz: ……..

26. Son 6 ay içerisinde yeme tutumunuzu etkileyecek bir durum yaşadınız mı? (Hamilelik, hastalık vb.) a. Evet b. Hayır

27. Son 6 aydaki yeme düzeninizi düşününce sizin için uygun olanları işaretleyin. (1'den fazla seçenek işaretleyebilirsiniz.)
    h. Birçok kişiye göre normalden çok fazla olarak değerlendirilebilinecek ölçüde yemek yedim.
    i. Sık sık yemek yemeyi kontrol edemeyeceğimi ve duramayacağımı hissettim.
    j. Normalden çok daha hızlı yedim.
    k. Rahatsız edici bir biçimde doyana kadar yedim.
    l. Fiziksel olarak açlık hissetmezken büyük miktarlarda yemek yedim.
    m. Ne kadar yediğim konusunda utanma nedeniyle yalnız başıma yedim.
    n. Aşırı yeme sonrası kendinden nefret etme, kendini suçlu ya da depresif hissettim

28. Düzenli olarak spor yapar mısınız? a. Evet b. Hayır

29. *Yanıtınız evet ise:* Ne sıklıkta spor yapıyorsunuz?
    e. Her gün / Neredeyse her gün
    f. Haftada birkaç kez (Sayısınız belirtiniz: ……)
    g. Haftada bir kez
    h. Ayda birkaç kez (Sayısını belirtiniz: ……..

APPENDIX C: EATING ATTITUDES TEST

Bu anket sizin yeme alışkanlıklarınızla ilgilidir. Lütfen her bir soruyu dikkatlice okuyunuz ve size uygun gelen şıkkı işaretleyiniz.

	Daima	Çok Sık	Sık Sık	Bazen	Nadiren	Hiçbir zaman
1. Başkaları ile birlikte yemek yemekten hoşlanırım.						
2. Başkaları için yemek pişiririm, fakat pişirdiğim yemeği yemem.						
3. Yemekten önce sıkıntılı olurum.						
4. Şişmanlamaktan ödüm kopar.						
5. Acıktığımda yemek yememeğe çalışırım.						
6. Aklım fikrim yemektedir.						
7. Yemek yemeyi durduramadığım zamanlar olur.						
8. Yiyeceğimi 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 dek egzersiz yaparım.						
17. Günde birkaç kere 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. (Erkekler yanıtlamaz.)						
24. Başkaları çok zayıf olduğumu düşünür.						
25. Şişmanlama (vücudumun yağ toplayacağı) düşüncesi zihnimi meşgul eder.						
26. Yemeklerimi yemek başkalarınınkinden daha uzun sürer.						
27. Lokantada yemek yemeyi 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 hissederim.						
34. Yiyecekle 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 D: EXPERIENCES IN CLOSE RELATIONSHIPS SCALE

Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde işaretleyiniz.

1 2 3 4 5 6 7
Hiç katılmıyorum Kesinlikle katılıyorum

	1	2	3	4	5	6	7
1. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.							
2. Terk edilmekten korkarım.							
3. Romantik ilişkide olduğum kişilere yakın olmak konusunda çok rahatım.							
4. İlişkilerim konusunda çok kaygılıyım.							
5. Birlikte olduğum kişi bana yakınlaşmaya başlar başlamaz kendimi geri çekiyorum.							
6. Romantik ilişkide olduğum kişilerin beni, benim onları umursadığım kadar umursamayacaklarından							
7. Romantik ilişkide olduğum kişi çok yakın olmak istediğinde rahatsızlık duyarım.							
8. Birlikte olduğum kişiyi kaybedeceğim diye çok kaygılanırım.							
9. Birlikte olduğum kişilere açılma konusunda kendimi rahat hissetmem.							
10. Genellikle, birlikte olduğum kişinin benim için hissettiklerinin benim onun için hissettiklerim kadar güçlü olmasını arzu ederim.							
11. Birlikte olduğum kişiye yakın olmayı isterim, ama sürekli kendimi geri çekerim.							
12. Genellikle birlikte olduğum kişiye tamamen bütünleşmek isterim ve bu bazen onları korkutup benden uzaklaştırır.							
13. Birlikte olduğum kişilerin benimle çok yakınlaşması beni gerginleştirir.							
14. Yalnız kalmaktan endişelenirim.							
15. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda oldukça rahatımdır.							
16. Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.							

17. Birlikte olduğum kişiyle çok yakınlaşmaktan kaçınmaya çalışırım.							
18. Birlikte olduğum kişi tarafından sevildiğimin sürekli ifade edilmesine gereksinim duyarım.							
19. Birlikte olduğum kişiyle kolaylıkla yakınlaşabilirim.							
20. Birlikte olduğum kişileri bazen daha fazla duygu ve bağlılık göstermeleri için zorladığımı							
21. Birlikte olduğum kişilere güvenip dayanma konusunda kendimi rahat bırakmakta zorlanırım.							
22. Terk edilmekten pek korkmam.							
23. Birlikte olduğum kişilere fazla yakın olmamayı tercih ederim.							
24. Birlikte olduğum kişinin bana ilgi göstermesini sağlayamazsam üzülür ya da kızarım.							
25. Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.							
26. Birlikte olduğum kişinin bana istediğim kadar yakın olmadığını düşünürüm.							
27. Sorunlarımı ve kaygılarımı genellikle birlikte olduğum kişiyle tartışırım.							
28. Bir ilişkide olmadığım zaman kendimi biraz kaygılı ve güvensiz hissederim.							
29. Birlikte olduğum kişilere güvenip dayanmakta rahatımdır.							
30. Birlikte olduğum kişi istediğim kadar yakınımda olmadığında kendimi engellenmiş							
31. Birlikte olduğum kişilerden teselli, öğüt ya da yardım istemekten rahatsız olmam.							
32. İhtiyaç duyduğumda birlikte olduğum kişiye ulaşamazsam kendimi engellenmiş hissederim.							
33. İhtiyaç duyduğumda birlikte olduğum kişiden yardım istemek işe yarar.							
34. Birlikte olduğum kişiler beni onaylamadıkları zaman kendimi gerçekten kötü hissederim.							
35. Rahatlama ve güvencenin yanı sıra birçok şey için birlikte olduğum kişiyi ararım.							
36. Birlikte olduğum kişi benden ayrı zaman geçirdiğinde üzülürüm.							

APPENDIX E: EMOTION REGULATION DIFFICULTIES SCALE

Aşağıda insanların duygularını kontrol etmekte kullandıkları bazı yöntemler verilmiştir. Lütfen her durumu dikkatlice okuyunuz ve sizin için uygun olanı işaretleyiniz.

	Neredeyse Her zaman	Çoğu Zaman	Yaklaşık Yarı Yarıya	Bazen	Neredeyse Hiçbir Zaman
1. Ne hissettiğim konusunda netimdir.					
2. Ne hissettiğimi dikkate alırım.					
3. Duygularım bana dayanılmaz ve kontrolsüz gelir.					
4. Ne hissettiğim konusunda net bir fikrim vardır.					
5. Duygularıma bir anlam vermekte zorlanırım.					
6. Ne hissettiğime dikkat ederim.					
7. Ne hissettiğimi tam olarak bilirim.					
8. Ne hissettiğimi önemserim.					
9. Ne hissettiğim konusunda karmaşa yaşarım.					
10. Kendimi kötü hissettiğimde, bu duygularımı kabul ederim.					
11. Kendimi kötü hissettiğimde, böyle hissettiğim için kendime kızarım.					
12. Kendimi kötü hissettiğimde, böyle hissettiğim için utanırım.					
13. Kendimi kötü hissettiğimde, işlerimi yapmakta zorlanırım.					
14. Kendimi kötü hissettiğimde, kontrolümü kaybederim.					
15. Kendimi kötü hissettiğimde, uzun süre böyle kalacağıma inanırım.					
16. Kendimi kötü hissettiğimde, sonuç olarak yoğun depresif duygular içinde olacağıma inanırım.					

17. Kendimi kötü hissettiğimde, duygularımın yerinde ve önemli olduğuna inanırım.					
18. Kendimi kötü hissettiğimde, başka şeylere odaklanmakta zorlanırım.					
19. Kendimi kötü hissettiğimde, kendimi kontrolden çıkmış hissederim.					
20. Kendimi kötü hissettiğimde, halen işlerimi sürdürebilirim.					
21. Kendimi kötü hissettiğimde, bu duygumdan dolayı kendimden utanırım.					
22. Kendimi kötü hissettiğimde, eninde sonunda kendimi daha iyi hissetmenin bir yolunu bulacağımı bilirim.					
23. Kendimi kötü hissettiğimde, zayıf biri olduğum duygusuna kapılırım.					
24. Kendimi kötü hissettiğimde, davranışlarımı kontrol altında tutabileceğimi hissederim.					
25. Kendimi kötü hissettiğimde, böyle hissettiğim için suçluluk duyarım.					
26. Kendimi kötü hissettiğimde, konsantre olmakta zorlanırım.					
27. Kendimi kötü hissettiğimde, davranışlarımı kontrol etmekte zorlanırım.					
28. Kendimi kötü hissettiğimde, daha iyi hissetmem için yapacağım hiçbir şey olmadığına inanırım.					
29. Kendimi kötü hissettiğimde, böyle hissettiğim için kendimden rahatsız olurum.					
30. Kendimi kötü hissettiğimde, kendim için çok fazla endişelenmeye başlarım.					
31. Kendimi kötü hissettiğimde, kendimi bu duyguya bırakmaktan başka yapabileceğim bir şey olmadığına inanırım.					
32. Kendimi kötü hissettiğimde, davranışlarım üzerindeki kontrolümü kaybederim.					
33. Kendimi kötü hissettiğimde, başka bir şey düşünmekte zorlanırım.					
34. Kendimi kötü hissettiğimde, duygumun gerçekte ne olduğunu anlamak için zaman ayırırım.					
35. Kendimi kötü hissettiğimde, kendimi daha iyi hissetmem uzun zaman alır.					
36. Kendimi kötü hissettiğimde, duygularım dayanılmaz olur.					

KATILIMINIZ İÇİN TEŞEKKÜR EDERİZ!!! ☺