RELATIONSHIP BETWEEN ORTHOREXIA NERVOSA AND MENTALIZATION: THE MEDIATING ROLE OF EMOTION REGULATION

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PLAGIARISM

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ABSTRACT

Variables of this study, orthorexia nervosa, mentalization are new concepts in the literature and studies on these subjects have increased recently. This study aims to investigate whether there is a relationship between orthorexia nervosa and reflective functioning (mentalization) through the possible mediator role of emotion regulation difficulties. The study was conducted by using correlation analysis. The Reflective Functioning Questionnaire (RFQ-8) - Short Version scale was used to measure mentalization capacity, the Difficulties in Emotion Regulation Scale-Brief Form (DERS-16) scale to measure emotion regulation difficulties, and the ORTO-11 Inventory scale to measure orthorexia nervosa. A total of 200 participants in the ages between 18 and 45 are participated in the study. The findings of the study show there is not a significant relationship between reflective functioning and orthorexia nervosa. The results also indicate no significant relationship between orthorexia nervosa and difficulty in emotion regulation. Yet there is a positive and statistically significant effect of reflective functioning on emotion regulation difficulties. Finally, findings shows no significant mediator role of emotion regulation between reflective functioning and orthorexia nervosa. Although some of the results of the study are compatible with the literature, different results are also found and the possible reasons for these findings are discussed. The variables of this research are the new topics in the literature and this study aims to contribute to this newly formed literature. It is hoped that the results of the study will be an opportunity for new studies.

***Keywords**: emotion regulation, mentalization, orthorexia nervosa, reflective functioning*

ÖZET

Bu çalışmanın değişkenleri olan ortoreksiya nervoza, mentalizasyon literatürde yeni kavramlar olup bu konulardaki çalışmalar son zamanlarda artış göstermiştir. Bu çalışma duygu düzenleme güçlüklerinin olası aracı rolü üzerinden ortoreksiya nervoza ile Yansıtıcı İşlevler (zihinselleştirme) arasında bir ilişki olup olmadığını araştırmayı amaçlamaktadır. çalışma korelasyon analizi kullanılarak yapılmıştır. Zihinselleştirme kapasitesini ölçmek için Yansıtıcı İşleyiş Ölçeği (YİÖ-8) - Kısa Versiyon ölçeği, duygu düzenleme güçlüklerini ölçmek için Duygu Düzenleme Güçlüğü Ölçeği-Kısa Form (DERS-16) ölçeği ve ortoreksiya nervozayı ölçmek için ORTO-11 envanter ölçeği kullanıldı. Çalışmaya 18-45 yaş arası toplam 200 katılımcı katılmıştır. Araştırmanın bulguları, yansıtıcı işlevsellik ile ortoreksiya nervoza arasında anlamlı bir ilişki olmadığını göstermektedir. Sonuçlar aynı zamanda ortoreksiya nervoza ile duygu düzenleme güçlüğü arasında anlamlı bir ilişki olmadığını göstermektedir. Yine de duygu düzenleme güçlükleri üzerinde yansıtıcı işlevin pozitif ve istatistiksel olarak anlamlı bir etkisi vardır. Son olarak, bulgular, duygu düzenlemenin yansıtıcı işlevsellik ile ortoreksiya nervoza arasında anlamlı bir aracı rolü olmadığını göstermektedir. Çalışmanın sonuçlarının bir kısmı literatür ile uyumlu olmakla birlikte farklı sonuçlara da rastlanmakta ve bu bulguların olası sebepleri tartışılmaktadır. Bu araştırmanın değişkenleri literatürdeki yeni konulardır ve bu çalışma bu yeni oluşan literatüre katkı sağlamayı amaçlamaktadır. Çalışma sonuçlarının yeni çalışmalara fırsat olması umulmaktadır.

***Anahtar Kelimeler**: : duygu düzenleme, ortoreksiya nervoza,, yansıtıcı işlevsellik, zihinselleştirme*

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1.1 Definition of Mentalization

Mentalization, or reflective functioning can be defined as an individual's fundamental ability to grasp and interpret intentional mental states within themselves or others. This concept covers numerous domains including attitudes, goals, wishes and desires (Luyten et al., 2020). The concept of mentalization has emerged as a revolutionary contribution by the efforts of Peter Fonagy and his colleagues (Bateman & Fonagy, 2016; Fonagy et al., 1991; Fonagy et al., 2002). Fonagy et al. have explored the intricate nature of mental process comprehension, providing crucial insights into its diverse utility in several domains such as psychology, therapeutic practices, and interpersonal relations. Their research has not only enriched our understanding of this concept but also showcased its practical implications (Fonagy et al., 2002).

Mentalization, operationalized as reflective functioning has been a subject of substantial discussion within psychoanalytic and cognitive frameworks (Björgvinsson & Hart 2008; Fonagy 1991; Morton & Frith 1995). Many studies have delved into the intricate psychological processes associated with the Reflective Function, thereby enriching our understanding of this concept (Cucchi et al., 2018; Finn et al., 2019; Kennedy-Turner et al., 2022; Levy et al., 2006; Rothschild-Yakar et al., 2013). Originating from attachment theory as proposed by Fonagy and Target (1997) and further elaborated by Allen et al. (2013), the Reflective Function serves as a gauge of mentalizing capacity. This function plays a key role in helping us comprehend the depth and nuances of mentalization, thereby expanding the horizons of our understanding of human psychology.

1.2 The Development of Mentalization

Freud's influence on psychoanalysis was particularly crucial in the development of mentalization. Freud never used the term directly, but his work was fundamental in explaining how non-mental phenomena are transformed into mental entities through mentalization. He was concerned with the complex relationship

between spoken words and thoughts and established a link between the energy of language and cognitive processes (Allen 2013; Freud 1895; Pribram & Gill 1976).

There are various approaches to mentalization within the psychoanalytic school. The first, often referred to as the French school of mentalization, grew from Marty's studies on somatization (Marty, 1991 as cited in Freeman, 2016). This perspective focuses on the mental interpretation of the emotional world through symbolizations and representations (Marty, 1991 as cited in Freeman, 2016). The second approach was introduced by Fonagy and Target (1997) and framed mentalization as reflective functioning, a process that enables individuals to understand the mental states underlying their own behavior and the behavior, beliefs, and attitudes of others. This capacity for reflection is associated with psychological clarity, self-awareness, and empathy, with cognitive-emotional capabilities furthering our understanding of intentions and mental states in connection to actions and attitudes (Fonagy et al., 2002).

Allen and Fonagy (2006) advanced the understanding of mentalization by integrating elements from psychoanalysis, developmental psychology, and attachment theory into a comprehensive theoretical framework. Following Bowlby, who emphasized the critical role of primary caregivers in a baby's early relationships, they examined the significance of this bond in shaping the child's lifelong social, cognitive, and emotional growth (Allen et al., 2013; Fonagy et al., 2002 p.49). This perspective was expanded upon by other researchers who aligned attachment theory with the importance of maternal mental-state conversation with the child, thereby fostering the child's ability to express inner states through language (Allen & Fonagy, 2006).

In contrast, Winnicott (1971) underscored the critical role of reflective mirroring in fostering mentalization, as referenced in Allen and colleagues' work (2013). He postulated that a child's mental self-concept is shaped by seeing his or her self-image reflected in another's mind, predominantly the mother's (Fonagy & Target, 1997). Secure attachment, characterized by careful attention to emotions and underlying thoughts, plays a critical role in this process. This secure attachment is

thought to enhance a child's mentalizing ability by allowing him or her to explore, experience, recognize, normalize, and regulate unfamiliar emotions and thoughts (Allen et al., 2013). The relationship between secure attachment and mentalization is critical because it fosters interactions that promote mentalizing processes (Allen et al., 2013). Secure emotional bonds, reinforced by secure attachment, enhance situational reactivity and facilitate effective emotion regulation through mentalization (Meins et al., 2001).

Mentalization incorporates a myriad of constructs including empathy, theory of mind, emotion awareness, and mind reading, all of which overlap considerably (Choi-Kain & Gunderson, 2008). As a result, the definition of mentalization has been expanded to include these facets, creating a comprehensive framework that fully captures the multi-dimensional nature of human social cognition and emotional comprehension. This holistic approach accentuates the complex interaction between these concepts and highlights the central role of mentalization in social interactions and interpersonal dynamics. Strong mentalization abilities are crucial for successful life navigation and the formation of meaningful interpersonal relationships, as Allen and his colleagues (2013) assert. In contrast, deficiencies in these abilities can lead to numerous challenges, including psychopathology. Therefore, the ability to recognize, articulate, and manage behaviors and emotions in relation to our needs, thoughts, and feelings is essential for establishing and maintaining communication with others (Allen et. al., 2013). Thus, mentalization emerges as a key factor in building and sustaining healthy relationships, fostering empathy, mutual understanding, and effective social exchanges.

Mentalization and reflective functioning are considered valuable indicators of a complex psychological capacity that is closely intertwined with self-representation. (Fonagy & Target 1997). According to Fonagy and colleagues, this capacity is exemplified by the empathic ability to understand the thoughts and feelings of others and integrate them into one's own experiences (Allen et al., 2013, p. 13). This capacity includes self-awareness, introspection, and the ability to navigate the complexity of our internal and external realities with sensitivity and understanding.

1.3 Dimensions of Mentalization

There are four dimensions have elaborated on the concept of mentalization by identifying four distinctive aspects: the implicit versus explicit, the internal versus external, the cognitive versus emotional, and self-oriented versus others oriented (Bateman & Fonagy, 2019). First dimension is related to two modes of functioning that involve implicit (or automatic) and explicit (or controlled). Automatic (or implicit) mentalization relates to reflective processes that are reasonably quick and involve minimal awareness or effort (Fonagy & Luyten, 2016). Conversely, explicit (or controlled) mentalization involves more conscious, intentional, and sporadic projective processes. The concept of controlled mentalization refers to a context where understanding another person's viewpoint is not immediately accomplished and demands some level of effort (Allen et al., 2013). The term "explicit mentalization" is used to portray a process that is premeditated, articulated, and thoughtful. The speed of this process depends on the existing conditions and can vary from rapid to slow. It is marked by the application of cognitive labor, focused attention, deliberate intention, and self-consciousness (Allen et al., 2013). Through the operation of explicit mentalization, feelings and cognitions are transformed into symbolic representations, such as verbal communication, therapeutic art, or narrative storytelling. As underscored by Allen and colleagues (2013, p. 36), narratives are crucial in explicit mentalization, acting as a primary mechanism for deploying language for this function.

Another dimension of mentalization focuses on the self-other aspect, recognizing mentalization as both an intrapersonal and interpersonal phenomenon, as it allows individuals to examine their own minds as well as intentions and internal processes of others. (Allen et al., 2002; Fonagy and Luyten, 2009; Jensen, et al., 2021). Here, Fonagy and colleagues introduced the concept of mentalized affectivity to define and understand the concept of self-awareness (Fonagy et al., 2002; Jurist, 2005). Being aware of one's affects while in the affective state and viewing one's emotional experiences as meaningful are components of the concept of mentalized affectivity. (Fonagy et al., 2002, p. 96). Mentalized affectivity is critical to emotion

regulation, which involves recognizing, modifying, and expressing emotions, —not only to others, but also to oneself (Fonagy et al., 2002 p. 11).

The third dimension of mentalization divides into internal and external categories. Internal mentalization directs attention to the individual's internal world, thoughts, emotions, and intuitive processes, while external mentalization involves interpreting the mental states of others through external cues (Fonagy and Luyten, 2009).

The fourth and final dimension of mentalization distinguishes between emotion-oriented and thought-oriented (cognitive) mental processes. Cognitive mentalization involves perceiving, naming, and understanding the causes of internal states, whereas emotional mentalization involves managing the emotions associated with those internal states (Allen et al., 2013; Allen & Fonagy, 2002).

Challenges within these dimensions can lead to a lack of mentalization, which can impair emotional regulation and understanding of one's and other people's thoughts, emotions, and behaviors, as well as the ability to manage emotions, and can impact interpersonal relationships, leading to miscommunication, misunderstanding, or lack of empathy (Bateman & Fonagy 2019).

Effective emotional regulation, however, is a key benefit of mentalization skills, which allow individuals to perceive themselves from an external viewpoint and understand others' experiences from an internal perspective (Robinson & Skarderud, 2019). Mentalization contributes significantly to relationships and communication, enabling individuals to navigate social situations with empathy and a deeper understanding of others' intentions, emotions, and thoughts. It allows individuals to competently manage and identify their emotions, leading to the adaptive expression of feelings.

The framework of mentalization theory has provided significant insights into the origins of various psychological disorders, as research has indicated that a deficiency in mentalization can notably exacerbate the emergence of diverse psychological manifestations (Allen et al., 2008).

Consequently, mentalization-based therapies have been developed to aid individuals struggling with emotion regulation, including those diagnosed with borderline personality disorder or eating disorders (Bateman & Fonagy, 2010; Skårderud & Fonagy, 2012).

Therapies centered around mentalization are frequently utilized for patients grappling with major issues in emotion regulation, like borderline personality disorder and eating disorders (Bateman & Fonagy, 2010; Skårderud & Fonagy, 2012), and mentalization also functions as a therapeutic strategy in treating diverse disorders, encompassing depression, eating disorders, and post-traumatic stress disorder. Moreover, it has been implemented with numerous individuals experiencing attachment concerns and social impairments (Allen et al., 2008).

1.4 Mentalization and Eating Disorders

Mentalization, as defined by Robinson, and colleagues (2019), is a core human capacity that is crucial for effective communication and fostering interpersonal relationships. It involves the ability to perceive oneself and others from both external and internal perspectives. A heightened mentalizing capacity typically signifies adaptability and flexibility in thought and relational patterns. Conversely, its deficiency can impede the formation of meaningful social connections, leading to feelings of isolation (Robinson et al., 2019).

Mentalization theory suggests that eating disorders result from a compromised sense of self, primarily due to an inability to engage in mentalizing during social experiences (Bateman & Fonagy, 2016). This culminates in the predominance of pre-mentalizing modes of function, which involve primitive mental processes that hinder the accurate perception and understanding of one's own and others' mental states; In the context of eating disorders, these modes contribute to a distorted self-perception, emotional regulation difficulties, and interpersonal challenges.

Studies by Kuipers and Bekker (2012) reveal a robust correlation between reduced mentalizing capacity and symptoms of eating disorders, a finding echoed in the systematic review by Simonsen and colleagues (2020). These findings are significant because they support the idea that impaired mentalizing capacity is a characteristic trait of populations affected by eating disorders.

The notion of mentalizing incorporates several elements, each providing an opportunity to scrutinize its neurological underpinnings and related psychological mechanisms (Luyten et al., 2020). For instance, alexithymia is a significant aspect and refers to the inability to identify, verbalize, and comprehend one's emotions, signifying self-mentalization difficulties. Theory of Mind (ToM) is another aspect that refers to the capacity to mentalize others (Fonagy et al., 2012 as cited in Simonsen et al., 2020).

Numerous studies demonstrate a consistent correlation between mentalization issues and the prevalence of eating disorders. For instance, Harrison et al. (2010) discovered that individuals with eating disorders encounter greater challenges with emotion regulation compared to control groups. A meta-analysis by Bora and Köse (2016) also identified substantial impairments in ToM among individuals with eating disorders.

The study included over 150 studies, unveiling a multitude of cognitive, interpersonal, and social issues linked with an eating disorder diagnosis. This research highlights the considerable social difficulties individuals with eating disorders face and the vulnerability of their social identities (Bateman & Fonagy, 2019; Caglar-Nazali et al., 2014). In clinical settings, mentalization is paramount as it facilitates emotion regulation, identity development, self-understanding, and comprehension of others. However, research has identified significant reductions in self-agency, negative self-perception, limited understanding of mental processes, and heightened sensitivity to social dominance in individuals with eating disorders (Caglar-Nazali et al., 2014). These findings underline the need to contemplate social processes when tackling these conditions, considering the complex interplay between eating disorders and social elements (Bateman & Fonagy, 2019).

Individuals with eating disorders often have difficulty with social interactions, which leads to feelings of isolation and a desire for connection (Bateman & Fonagy, 2019). Impaired mentalization can cause misunderstanding and confusion, triggering behaviors such as withdrawal, hostility, and overprotection, disrupting relationships and perpetuating an insecure and uncontrollable environment(Ball Cooper et al., 2021; Fonagy & Luyten 2009; Sharp & Fonagy 2008).

Individuals with orthorexia nervosa, for instance, may avoid social gatherings to escape criticism, resulting in decreased social and physical activity (Varga et al., 2013). Disorders such as orthorexia nervosa and anorexia nervosa can lead to social isolation and disrupt a person's social life due to disruptive eating patterns that can cause conflict or take up excessive amounts of time (McComb & Mills 2019).

Research by McAdams and Krawczyk (2011) shows that even individuals who have recovered from anorexia nervosa may still exhibit a lack of activation in the mentalization network during tasks requiring social attributions. This underscores the ongoing impact of eating disorders on social cognition and interaction. Comprehending the thoughts and feelings of others while managing one's own is crucial for successful social engagements (Bateman & Fonagy, 2019). As a result, robust social connections can significantly aid in developing better coping strategies to manage the intricacies linked to such disorders. Mentalization, a key psychological process, encompasses the understanding and interpretation of both personal experiences and those of others. It is instrumental in dealing with complex situations, managing external and internal influences, and nurturing positive relationships (Bleiberg, 2004, as cited in Golan & Mozeikov, 2021). Within the scope of eating disorders, a diminished capacity to mentalize might intensify the disorder, potentially leading to a breakdown in personal relationships and ensuing negative consequences (Espelage et al., 2000; Keel et al., 2005).

1.5 Orthorexia Nervosa

"Orthorexia nervosa" is still relatively a new term and has just been recently referred to as an eating disorder in the medical community. Despite its absence from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Classification of Diseases (ICD-10), guidelines for diagnostic assessment have been established by Dunn and Bratman (2016). A key criterion is an intense obsession with consuming "healthy" food, inducing psychological distress when faced with anything deemed unhealthy (Cena et al., 2019; Dunn & Bratman 2016).. A notable characteristic is a fear of food contamination. Overeating, although often linked to orthorexia, is only one facet of this intricate disorder. Characteristics of orthorexia

include a preoccupation with the quality and purity of food, strict dietary rules, strong feelings of guilt or anxiety when these rules are not followed, an obsession with food sources and preparation, and a distorted sense of self-worth based on adherence to these dietary beliefs (Arusoglu, 2019).

The word "orthorexia", which originated in Greek, was coined by Steven Bratman, who combined the terms "right" and "appetite". This corresponds to the pursuit of an "appropriate appetite" (Bratman, 1997 as cited in Donini et al., 2004). Bratman originally developed the term to describe those who have an irrational concern about their diet. Their behaviors include self-imposed food restrictions, preoccupation with food preparation, and a strict diet plan (Koven & Abry, 2015). These individuals are extremely concerned about their dietary choices, lifestyle, and adherence to strict eating routines that they believe make them feel good about themselves (Cena et al., 2019).

Deviations from typical behaviors, negative effects, and functional limitations can transform what is initially perceived as a less severe eating disorder, orthorexia nervosa, into a series of harmful behaviors and distorted attitudes. Even when a healthy diet is considered beneficial to health, Varga and colleagues note that the disorder can become increasingly severe (Varga et al., 2013).

The study of the causes of orthorexia has become a relatively popular topic in recent years, aiming to identify numerous predisposing factors that contribute to the condition. Researchers have shed light on the relationship between orthorexia nervosa and eating disorder symptoms to gain a better understanding of the conditions underlying and associated with the disorder (Novara et al., 2021; Novara et al., 2022; Segura et al., 2015). Individuals prone to orthorexia nervosa have difficulties in social activities and relating to those around them (Ab Hamid et al. 2018). In support of these findings, one study shows that people with orthorexia nervosa often withdraw from social situations to avoid criticism and judgment; as a result, their levels of social and physical activity decrease (Varga et al. 2013).

Orthorexia nervosa shares common symptoms with other eating disorders, notably social isolation and perfectionism. Individuals suffering from orthorexia nervosa often experience guilt and shame, leading to feelings of social seclusion when they fail to adhere to their strict dietary rules (Cartwright, 2004). Barnes and

Caltabiano (2017) discovered a link between perceived perfectionism and reported orthorexic symptoms. Such individuals obsess over the nutritional content of each meal, prioritizing nutritional content over caloric intake. This preoccupation with healthy eating can cultivate the erroneous belief that there is only one correct way to eat. Initially, pursuing a healthy diet may seem like a step towards a healthier lifestyle, motivated by the desire to prevent disease, enhance longevity, or lose weight. However, for some, it can evolve into an unhealthy obsession as they increasingly dedicate time and resources to acquiring, preparing, and consuming healthy food. Over time, this shift can negatively impact social functioning, overall well-being, and mental health, as shown by Oberle et al. (2017).

Research suggests that the multifaceted impact of orthorexia nervosa extends beyond physical health. Troublesome eating habits negatively impact self-esteem and social anxiety, leading to outcomes such as social isolation and depressive symptoms (Sfeir et al., 2021). The relationship between orthorexia nervosa and its wide-ranging effects are evident in the environmental, physical, and social facets involved. Furthermore, Gkiouleka et al. (2022) reported that orthorexia nervosa symptoms can hinder an individual's ability to engage in normal daily life and social interactions.

There has been increased focus recently on understanding orthorexia nervosa, and researchers have employed various methods to assess this disorder. Gleaves et al. (2013) proposed a comprehensive multidimensional model of orthorexia nervosa that includes three primary aspects. The first dimension, "Concerns about healthy eating," encompasses evidence of misguided attempts to eat healthily. The second dimension, "Knowledge about healthy eating," covers cognitive aspects linked to a strong interest in healthy eating. The third dimension, "Positive feelings towards healthy eating," comprises emotional aspects associated with an unhealthy obsession with healthy food. Notably, prior research has found a connection between these dimensions of orthorexia and eating disorder symptomatology (Brytek-Matera et al., 2020; Pratt et al., 2023).

The capacity to understand and express both one's own experiences and those of others is an essential component of mentalization, which is critical for individuals to cope with difficult situations, maintain control over external and internal forces, and

establish positive relationships with others (Bleiberg, 2004, as cited in Golan & Mozeikov, 2021). This is especially true in cases of eating disorders, where a predisposition to these disorders can lead to an increased tendency for existing interpersonal relationships with loved ones to deteriorate and have negative consequences (Espelage et al., 2000; Keel et al., 2005).

Various studies have underscored the shared traits between orthorexia nervosa and eating disorders, especially anorexia nervosa. These traits include perfectionism, fixation on appearance, desire for thinness, interpersonal distrust, body consciousness, and challenges in emotion regulation (Barnes, 2017; Costanzo et al., 2022; Parra-Fernandez, 2018; Vuillier et al., 2020). Orthorexia is often depicted in popular discourse as the pursuit of a "perfect diet" (Schwartz, 2015; Pratt et al., 2023). These findings indicate overlapping features and underlying psychological factors contributing to both orthorexia and conventional eating disorders, underscoring the need for further research and understanding of these conditions.

Mac Evilly (2001) proposed the notion that orthorexia nervosa should be regarded as a risk factor and an early stage in the development of eating disorders rather than a distinct disorder in itself .This perspective suggests that the restrictive and obsessive eating patterns observed in orthorexia nervosa could potentially escalate and evolve into a full-blown eating disorder over time (Evilly, 2001, as cited in Niedzielski et al. 2021). Supporting this view, Niedzielski et al. (2021) have also emphasized the progressive nature of orthorexia nervosa, with the possibility of it transitioning into an eating disorder if left unchecked.

Investing too much time and energy in overly complex eating plans, avoiding social situations involving food, and isolating oneself are common sources of psychological distress in people with orthorexia nervosa (Segura et al., 2015). Although orthorexia is not dangerous in the immediate or physical sense, it can lead to medical problems when it becomes severe (Moroze et al., 2015; Park et al., 2011).

Malnutrition, one of the proposed diagnostic B criteria for orthorexia nervosa, is described as "severe weight loss or other medical complications from a restricted diet" (Dunn & Bratman 2016). Following recommended dietary practices conflicts with the compulsions and behaviors associated with orthorexia nervosa, which in turn leads to malnutrition (Cena et al., 2019; Moroze et al., 2015; Zamora et al., 2005).

People suffering from orthorexia nervosa have their own unique definition of what constitutes a healthy diet. Failure to strictly follow these guidelines can lead to emotional distress. Therefore, the potential harm of orthorexia nervosa is underscored by the relentless pursuit of the perfect diet, which can lead to malnutrition and emotional problems resulting from social consequences and extreme mental effort.

Excessive dopamine activity is associated with anorexic neuroses and restricted eating behaviors, according to recent neuroscience research by Golan in 2022. Accordingly, because of this neurochemical influence, individuals suffering from such conditions may tend to prioritize their compulsion to engage in restrictive eating behaviors at the expense of overcoming their innate feelings of hunger (Golan, 2021).However, attempting to regulate uncontrollable symptoms alongside manageable factors may be detrimental to individuals suffering from eating disorders. Another study by Golan et al. in 2021 uncovered a distinct imbalance in the emotional and prefrontal regions of the brain associated with inflexible and compulsive eating behaviors. This imbalance can lead to an excessive amount of control over food intake, resulting in a deficiency of important nutrients.

An extreme preoccupation with healthy eating and a lack of involvement in relationships may be symptoms of Orthorexia nervosa. This condition is often misunderstood as a distinct condition despite its potential for harmful behaviors such as an overabundance of measuring and an imbalance in food intake. A recent study by Barnes and Caltabiano (2017) found a correlation between perceived perfectionism and reported orthorexic symptoms, but more research is needed to understand how these two factors are related.

Individuals suffering from orthorexia nervosa have a strict desire to be pure and healthy in terms of their eating habits, and therefore adhere to a restrictive diet. Research has shown that those who are overly concerned about food quality have higher obsession scores (Hayes et al., 2017; Ramacciotti et al., 2011). Measuring and weighing food portions or participating in elaborate meal planning are behaviors associated with this fixation on food quality, and deviating from predetermined meal plans can lead to feelings of guilt (Bratman & Knight, 2000; Hayes et al., 2017). Orthorexics are concerned with the purity and healthfulness of the foods they

consume, resulting in a more restrictive dietary program. Orthorexics who are overly preoccupied with food have been found to score high on obsessions (Ramacciotti et al., 2011; Hayes et. al., 2017). In this sense, they tend to have obsessive methods of food preparation, the need to weigh and measure foods before eating them, make extensive plans for potential meals, and feel guilt when the plans made are not followed (Bratman & Knight, 2000; Hayes et al., 2017).

Similarly, Arusoğlu and colleagues (2008) conducted a study in Turkey that found that those who exhibited more severe obsessive-compulsive behaviors had lower ORTO-11 scores, indicating a greater propensity for orthorexia. Consequently, orthorexia may indeed be associated with obsessive-compulsive disorder (OCD) symptoms, and the findings also suggest that these symptoms may precede the development of orthorexic tendencies.

Orthorexia nervosa indeed presents a complex and multi-faceted problem, compounded by associated anxiety symptoms. Studies indicate that individuals battling this disorder often exhibit health anxiety (Kiss-Leizer et al., 2019), anxiety about appearance (Hayes et al., 2017), and social appearance anxiety (Eriksson et al., 2008). Furthermore, orthorexia nervosa is believed to be linked with a variety of psychological issues, including symptoms of obsessive-compulsive disorder, depressive symptoms, and a general lack of well-being (Andreas et al., 2018; Luck-Sikorski et al., 2019; Strahler et al., 2018). These observations emphasize the complex nature of orthorexia nervosa and underscore the need for a holistic approach in the comprehension and management of the disorder.

As outlined by Dunn and Bratman (2016), an obsessive focus on healthy eating forms a central attribute of this evolving eating disorder, underscoring the potential hazards of depending on certain food items for self-assurance and individual identity. Recent research has supported the theory by detecting a moderate positive correlation between orthorexia nervosa and health centered self-concept, consistent with accepted criteria for the disorder (Tabri et al., 2022; Yung & Tabri, 2022). In addition, Tabri et al.'s (2022) study showed that people who suffer from orthorexia nervosa often experienced stress because they are unable to control unhealthy food sources.

Both anorexia nervosa and orthorexia nervosa require a high degree of self-control to limit the amount of food consumed and, according to Varga et al. (2013), can lead to a sense of superiority over those who do not adhere to similar dietary restrictions. In addition, individuals suffering from orthorexia nervosa and anorexia nervosa often report feeling disgust and guilt when they fail to their dietary plans (McComb & Mills 2019; Mathieu, 2004). These similar characteristics underscore the psychological and emotional complexity of these disorders and also highlight the detrimental effects that restrictive dieting has on individuals and the negative feelings that result.

Looking at the gender prevalence of eating disorders, it is generally believed that women tend to have a higher awareness of dietary practices and are healthier overall, making them more susceptible to eating disorders (Mathieu, 2004). Research in Turkey that examined students' eating behaviors found that men are more likely to have orthorexia nervosa, although their numbers are lower than those of women (Arusoglu et al., 2008; Şanlıer et al., 2016; Varga et al., 2013).

In addition, eating disorders often occur during adolescence, a developmental stage characterized by significant physical, social, and psychological changes and challenges in which the above-mentioned difficulties play an important role. Developmental tasks during this stage include establishing one's identity and autonomy, learning to cope with interpersonal conflict, and separating from primary caregivers (Zeeck et al., 2021 Studies have shown that at least a subset of individuals with eating disorders have impaired mentalizing skills and insecure attachment patterns (Jewell et al., 2016). Our inability to effectively manage our emotions is at the root of many psychopathological conditions; this includes a lack of control over our emotions, all of which fall under the umbrella of mentalizing (Robinson et al., 2019).

1.6. Emotion Regulation

Difficulties in emotion regulation or maladaptive emotion regulation strategies are at the heart of many psychopathological disorders (Aldao et al., 2010). Gross's model of emotion regulation emphasizes that how we regulate our emotions and the

methods or strategies used to do so can have a significant effect over time and at different stages of our lives. The central component of this model consists of two main parts: cognitive reappraisal and emotional suppression (John & Gross 2004). According to Gross and John's definition, emotion regulation consists of components that are considered as two strategies. They explained that the first component, the person's cognitive reappraisal, and the second component, the suppression of emotions, effectively activate emotion regulation.

John and Gross (2004) theorized that past experience would facilitate emotional response in the future. Cognitive reappraisal, often practiced early on, helps us reinterpret events more effectively, whereas suppressing emotions can be problematic for people struggling to regulate their overall emotional state, as it requires them to hide their true inner workings (John & Gross, 2004). Emotion regulation is about changing your emotional state in response to external factors in a productive way. The capacity to effectively regulate our emotions depends on a comprehensive understanding of those emotions, whereby we can act appropriately even when they overwhelm us.

Emotion regulation is defined as a person's ability to modify their emotions in response to environmental demands. Successful emotion regulation includes general awareness, understanding, and acceptance of emotions, and the ability to act in spite of compelling emotions (Gratz & Roemer, 2004; Linehan, 1993; Smolak & Levine, 2015).

Grantz and Roemer's (2004) research shows that difficulties in emotion regulation are multidimensional and include both techniques for controlling emotional responses and emotion recognition skills. These findings highlight the importance of distinguishing between recognizing and understanding emotional responses and desired behaviors and avoiding undesired behaviors when experiencing unpleasant feelings (Grantz & Roemer, 2004).

It has been documented in the eating disorder literature that understanding or controlling one's feelings is critical to understanding the root causes of the disorder (Nowakowski et al., 2013). Orthorexia nervosa has a number of emotional consequences for those who experience its symptoms, including isolation, guilt, and self-loathing if they do not adhere to strict dietary guidelines (Cartwright, 2004).

These negative emotional responses illustrate the intricate link between emotions and the symptoms of orthorexia nervosa -an area of research that has already been examined in the larger eating disorder literature. Other studies have shown that there is a correlation between a person's fixation on healthy eating and their inability to effectively regulate their emotions.

As documented by Vuillier et al. (2020), individuals diagnosed with orthorexia nervosa often have difficulty finding appropriate coping mechanisms to deal with impulsive behavior during times of intense emotion. The study by Obeid et al. (2021) found similar results: Individuals who exhibited high levels of orthorexic tendencies often experienced difficulties when attempting to regulate their emotions, which is consistent with previous research on other eating disorders. All of these studies suggest that a deficiency in emotional processing may play an important role in the development or perpetuation of symptoms associated with orthorexia nervosa. However, they also illustrate that orthorexic behaviors serve as a form of coping for those who have difficulty in effectively regulating their emotions (Obeid et al., 2021; Vuillier et al., 2020).

According to the findings, difficulties in recognizing and regulating emotions make it difficult to comprehend social situations, can lead to complete avoidance of interpersonal relationships, and can cause social withdrawal (Harrison et al., 2009). It can lead to serious interpersonal problems because the person has difficulty reading other people's emotions and therefore cannot understand the impact of their behavior on family, social, and work environments.

Models that focus on stress responses related to the regulation of one's emotions have theoretical relevance to the link between psychopathology and difficulties in emotion regulation (Gross, 1998).

These models have improved understanding of how regulating one's emotions contributes to the development or maintenance of mental illness. For example, research suggests that individuals with eating disorders may engage in disordered eating behaviors to temporarily cope with negative emotions (Smyth et al., 2007). However, these methods perpetuate the disorder, leading to a constant cycle of reinforcement. Although the difficulties associated with regulating emotions and orthorexia nervosa have not been adequately studied, they are thought to have similar

causes. When people rely on a particular diet to control their emotions, it may initially seem beneficial to temporarily relieve emotional stress. Ultimately, however, this behavior may reinforce negative emotional states and promote distorted thinking patterns, which in turn sets in motion a vicious cycle of harmful coping mechanisms that lead to negative emotions (Golan, 2022; Oldershaw et al., 2019). The behavior associated with orthorexia nervosa may begin with a focus on healthy foods but can become an obsession over time (Bratman, 2017). Although both stages of orthorexia have difficulty in controlling their food intake while maintaining a healthy mental balance, the latter stage is more accurately representative of pathological behavior.

Lingiardi and McWilliams (2017) argue that mental function is the totality of its components, including mentalization, emotion and impulse regulation, the functioning of defense mechanisms, the ability to form intimate relationships, and the capacity for self-observation (Lingiardi & McWilliams, 2017, as cited in Costanzo et al., 2022).

As defined by the American Psychological Association (2013), negative affectivity is the experience of negative emotions such as depression, anxiety, guilt, and anger at high levels. These intense feelings often have a significant impact on behavior and interpersonal relationships. Strict adherence to dietary restrictions may lead to extreme negative emotions in people with orthorexia if they do not adhere to their meal requirements according to Dunn's 2016 research and Novara's 2022 research.

Skinner's research on emotion regulation addresses how individuals can effectively regulate stress during daily activities while also expressing their feelings appropriately (Skinner et al., 2003). Difficulties in emotion regulation often lead to unhealthy pathways of maladaptive coping that can negatively impact individuals' daily behaviors and lead to potentially irreversible psychopathologies. In their examination of the relationship between insecure attachment and disordered eating behaviors, Ty and Francis (2013) identified specific pathways through which one condition may lead to or exacerbate the other over time. Three potential mediators are social comparisons (to other people's body types), problems with regulating one's

emotions when distress arises, and (ultimately) early experiences with trusting relationships that may have led to anxiety or avoidance later in life (Ty & Francis, 2013). Eating disorders are a complex and multifaceted phenomenon; however, there is no simple answer to their cause. Instead, certain risk factors are often cited, including perfectionism, genetic predisposition, cultural pressures regarding the "ideal" body types, and individual psychological vulnerabilities such as neuroticism or an anxious attachment style (Bardone-Cone et al., 2007; Barnes& Caltabiano 2017; Strahler 2020).

The Current Study

Mentalization is a broad umbrella term consisting of many components that have been studied both by cognitive and developmental researchers (Astington & Hughes, 2013) within the framework of theory of mind, and from a psychoanalytic perspective (Allen et al., 2008; Fonagy et al., 1991) within the framework of reflective functioning. Individuals with high mentalizing capacity, i.e., good reflective function, can comprehend and respond flexibly to various changing interpersonal circumstances. People with high mentalization capacity can regulate their emotions by considering both their own and others' perspectives and maintaining a strong sense of who they are (Fonagy et al., 2002; Fonagy & Target, 1997).

The difficulty to regulate emotions is a fundamental aspect of various psychopathologies and has significant implications for psychosocial functioning, as research has shown (Gross & John, 2003; Kring & Werner 2004; Sheppes et al., 2015). Eating disorders have been linked to challenges in emotion regulation (Svaldi et al., 2012).

Orthorexia nervosa, a term that is relatively new in research circles, has been studied concerning its connection with symptoms of eating disorders, helping to shed light on its origins. Similarities are observed between orthorexia nervosa and eating disorders, especially anorexia and avoidant restrictive food intake disorder. These resemblances include inflexible behaviors and rituals linked to food preparation, stringent dieting, perfectionist tendencies, neurotic personality traits, and an intense need for control (Cena et al., 2017; Dell'Osso et al., 2016; Koven & Senbonmatsu

2013; Zamora et al., 2005). Considering the connection between challenges in emotion regulation and eating disorders, it is plausible to assume a similar mechanism might be operative in orthorexia nervosa.

To our knowledge, no research has specifically examined the potential direct or indirect link between reflective functioning and orthorexia nervosa. The connection between mentalization and emotion regulation has been a recurring theme in the literature, with many studies and articles suggesting a significant link between these two concepts. It is conceivable that a direct association exists between reflective functioning and orthorexia, or there may be an indirect link mediated through challenges in emotion regulation. There are reasons to suspect that mentalization difficulties may play a crucial role in the development of orthorexia. Thus, in connection with difficulties in emotion regulation, mentalizing may be useful in understanding the possible underlying psychopathology in orthorexia nervosa.

This study aims to examine the relationship between mentalization, orthorexia nervosa and difficulties in emotion regulation. In this context, the research aims to investigate the mediating effect of emotion regulation difficulties on reflective functioning and orthorexia nervosa. In other words, the main mediation hypothesis is based on whether emotion regulation difficulties mediate the relationship between individuals' reflective functioning and orthorexia nervosa.

2.METHOD

2.1. Procedure

First, approval was obtained from Yeditepe University Ethical Committee for conducting this study. Then, the demographic form and the other three scales were loaded into Google Drive Forms and sent to the participants online. It took approximately 8 minutes to complete all scales. Participants had to answer all questions in order to move on to the next scale. This was done to ensure that all answer sheets were completed without missing an answer.

2.2. Participants

In the present study, 200 participants took part in the survey. The age of the participants ranged from 18 to 43 years (M25.46, SD6.012). The sample was composed of 67 men (33.5%) and 132 women (66%). The detailed characteristics of the participants are shown in Table 1.

Information on gender, education, educational status, marital status, work status, and economic status was collected. 4 participants (2%) were graduated from junior high school, 78 participants (39%) were graduated from high school, 80 participants (40%) had a bachelor's degree, 32 participants (16%) were graduates, and 6 participants (3%) had a doctorate degree. 59.5% of the participants were in education. 160 participants (80%) were single, 36 participants (18%) were married, and 4 participants (2%) were divorced. 52.5% of participants were employed. Most of the participants' economic statuses were middle (56%), while 2% were lower, 11.5% were low, 28% were high, and 2.5% were higher.

Table 1

Socio-demographic Characteristics of the Participants

	N	M	SD	Percentage (%)
Gender (Age)	200	25.46	6.012	100.0
Male	67	24.51	5.221	33.5
Female	132	25.94	6.363	66.0
Binary	1	26.00	.	.5
Education				
Junior High School	4			2.0
High School (Lycee)	78			39.0
Bachelor	80			40.0
Graduate	32			16.0
PhD	6			3.0
Education Status				
Continuous	119			59.5
Not Continuous	81			40.5
Marital Status				
Single	160			80.0
Married	36			18.0
Divorced	4			2.0
Working Status				
Working	105			52.5
Not Working	95			47.5
Economic Status				
Lower	4			2.0
Low	23			11.5

Middle	112	56.0
High	56	28.0
Higher	5	2.5

2.3. Instruments

This study asked participants to fill out a demographic form (See Appendix B) and three different scales. To assess the level of mentalization; Reflective Functioning Questionnaire (RFQ)- Short Form was given (See Appendix C). The Orto-11 scale was used for the orthorexia nervosa measurement; (see Appendix D). Difficulties in Emotion Regulation Scale-Brief Form (DERS-16) (see Appendix E) was used for emotion regulation measurement.

2.3.1. Socio-demographic Form.

The sociodemographic form was used by researchers to collect information on age, gender, education, educational status, marital status, work status, and economic status.

2.3.2. The Reflective Functioning Questionnaire (RFQ).

For this study, the Reflective Functioning Scale (RFS) is used. This scale was developed by Fonagy et al. (2016) to evaluate an individual's ability to understand their own and others' mental states (mentalization). The original version of this Likert scale consists of 26 items that participants can answer on a scale from 1 (totally disagree) to 7 (totally agree). In the adult sample, Cronbach's alpha values ranged from .64 to .71.

The RFQ-Short form consists of 8 items and is a 7-point Likert type scale (1 = I strongly disagree, 7 = I strongly agree).

The adaptation study of this scale in Turkish sample has not been conducted yet (see appendix C). The developers of this scale provided items in Turkish on the their own website (UCL, 2019). Although there is no adaptation study in Turkish, many

graduate thesis studies in Turkey used this version (Göktaş 2021; Gör 2021; Yayla 2020). Göktaş (2021) reported Cronbach alpha values of .76 for the certainty subscale and .75 for the uncertainty subscale. Gör (2021) reported Cronbach's alpha values as .76 for the certainty dimension and .58 for the uncertainty dimension. Yayla (2020) reported that the Cronbach's alpha coefficient for the certainty subscale was determined to be 0.73, while for the uncertainty subscale it was found to be 0.68.
In this study, Cronbach alpha values for the subscales were calculated and found to be .67 for certainty and .70 for uncertainty. The Cronbach alpha value was found to be .74
for the overall scale.

2.3.3. Orthorexia Nervosa Scale (ORTO-11).

The Orthorexia Short Question Paper with 10 questions was used by Bratman (2000) for ON measurement. This scale was developed by Donini et al. (2005), who developed a 15-item self-report scale called ORTO-15 by modifying and improving these statements. ORTO-15 is a 4-point Likert-type ("always", "often", "sometimes" and "never") measurement tool that assesses individuals' ON tendency by examining their behavior in selecting, purchasing, preparing, and consuming healthy foods. Low scores on the scale indicate an orthorexic tendency. Reliability and validity studies for the Turkish version of the scale were conducted by Arusoğlu et al. (2008).
11 items were identified that are adapted to the Turkish language. Statistically, three factors with high power were identified: "concerns about healthy eating", "food selection and eating attitudes and behaviors" and "food selection and value" It was stated that it would be more appropriate to consider the ORTO11 scale as a single factor structure when we included the new factor analysis findings. In the final adaptation of the scale (4 items were removed), the scores are in the opposite direction for the 6th item and 2-4-3-1 for the 10th item. The total score ranges from 11 to 44, and as the score increases, the orthorexic tendency decreases. In this study, the scale was used to assess participants' orthorexic tendencies. The overall Cronbach Alpha coefficient of the scale over 15 items was 0.44, while this value was 0.62 when

calculated over 11 items. In this study, Cronbach's alpha value was found .63 for this scale.

2.3.4. Difficulties in Emotion Regulation Scale-Brief Form (DERS-16).

The DERS-16 was developed by Bjureberg et al. (2016) and consists of a 16-item self-report instrument. It was developed as a short version of the Difficulties in Emotion Regulation Scale (DERS) (Gratz and Roemer 2004). It is a questionnaire designed to assess several areas of difficulty in emotion regulation such as clarity, goals, impulses, strategies, and non-acceptance. In the initial study conducted by Bjureberg et al. (2016), the DERS-16 showed high internal consistency (α = .92) and good test-retest reliability (r = 0.85).

The Turkish adaptation of the DERS-16 was developed by Yiğit and Guzey Yiğit (2019). DERS-16 is 5-point Likert-type (1=never, 5=almost always). Validity and reliability of the scale were tested in the Turkish version. And the internal consistency coefficient Cronbach's Alpha was calculated to be .92 and the test-retest reliability was calculated to be .85 (Yiğit, & Guzey Yiğit, 2019). In the current study, the Cronbach alpha value was found to be .90 for this scale.

2.4. Data Analysis

The statistical analyses were conducted by IBM SPSS version 26. Before conducting statistical analysis normality assumption was tested by calculating Skewness and Kurtosis values. According to the recommendation of Tabaschnick and Fidell (2013), all scores were accepted as normally distributed because of Skewness – Kurtosis values which were between ±1.5 for all scales. The results of normal distribution are shown in Table 2 in the Results chapter.

3.RESULTS

The first aim of this study is to investigate the role of difficulties in emotion regulation on relationship between reflective functioning and orthorexia nervosa. Second, to examine the differences between emotion regulation difficulties, reflective functioning, and orthorexia nervosa according to participants' sociodemographic characteristics.

3.1. Descriptive Statistics

Descriptive information was calculated as mean scores, standard deviations, minimum-maximum values for the measures of scales, and skewness-kurtosis values for normal distribution. It is found that scores of the scales were normally distributed in accordance with the recommendation of Tabaschnick and Fidell (2013). The descriptive results are presented in Table 2.

Table 2

Descriptive Statistics of the Study Variables

Measures	N	Min	Max	M	SD	Skewness	Kurtosis
RFQ - TOTAL	200	9	53	30.93	8.914	.100	-.486
DERS - TOTAL	200	18	79	45.59	14.797	.134	-.868
Clarity	200	2	10	5.18	2.044	.460	-.284
Goals	200	3	15	10.67	3.082	-.347	-.743
Impulse	200	3	15	7.76	3.541	.347	-.912
Strategies	200	5	25	14.20	5.663	.140	-1.005
Non acceptance	200	3	15	7.79	3.622	.363	-1.035
ORTO - TOTAL	200	14	39	28.17	4.447	-.103	-.113

3.2. Between Group Comparisons

As an aim of this thesis between groups comparison analyses were conducted for the variables of the study according to socio-demographic characteristics of the sample.

Independent samples t test showed that there were no significant differences between main scores of the RFQ total, the DERS total and its subscales, and the ORTO total according to gender accept Goals subscale of DERS (Table 3). It is found out that DERS-Goals scores of female participants (M=11.02) were significantly higher than male participants' (M=9.91) main scores (t=-2.425; p=.016).

Table 3

Main scores of RFQ total, DERS total and its subscales, and ORTO total according to gender and Independent samples t test

	Gender	N	M	SD	t	p
RFQ - TOTAL	Male	67	30.37	9.118	-.586	.558
	Female	132	31.16	8.844		
DERS - TOTAL	Male	67	44.94	14.868	-.388	.699
	Female	132	45.80	14.811		
Clarity	Male	67	5.42	2.154	1.163	.246
	Female	132	5.06	1.991		
Goals	Male	67	9.91	3.103	-2.425	**.016***
	Female	132	11.02	3.004		
Impulse	Male	67	7.93	3.548	.499	.618
	Female	132	7.66	3.559		
Strategies	Male	67	14.15	5.785	-.029	.977
	Female	132	14.17	5.621		
Non acceptance	Male	67	7.54	3.560	-.655	.513
	Female	132	7.89	3.664		
ORTO - TOTAL	Male	67	28.96	4.507	1.726	.086
	Female	132	27.81	4.377		

*p<.05

One way ANOVA test showed that there is significant differences between main scores of total RFQ according to education [F(2-197)=5.067; p=.007]. As a result of the post hoc Tukey test carried out to determine the source of the difference, RFQ scores of those with high school (M=33.17) education were found to be significantly higher than those with graduate and above (M=28.21) education (p=.012). There is significant differences between main scores of total DERS according to education [F(2-197)=13.114; p=.000]. As a result of the post hoc Tukey test carried out to determine the source of the difference, DERS scores of those with high school (M=51.54) education were found to be significantly higher than those with bachelor (M=42.34) education (p=.000) and those with graduate and above (M=39.58) education (p=.000). There is significant differences between main scores of DERS-Clarity according to education [F(2-197)=6.649; p=.002]. As a result of the post hoc Tukey test carried out to determine the source of the difference, Clarity scores of those with high school (M=5.73) education were found to be significantly higher than those with graduate and above (M=4.37) education (p=.002). There is significant differences between main scores of DERS-Goals according to education [F(2-197)=9.221; p=.000]. As a result of the post hoc Tukey test carried out to determine the source of the difference, Goals scores of those with high school (M=11.74) education were found to be significantly higher than those with bachelor (M=9.90) education (p=.000) and those with graduate and above (M=9.95) education (p=.006). There is significant differences between main scores of DERS-Impulse according to education [F(2-197)=5.354; p=.005]. As a result of the post hoc Tukey test carried out to determine the source of the difference, Impulse scores of those with high school (M=8.68) education were found to be significantly higher than those with bachelor (M=7.30) education (p=.032) and those with graduate and above (M=6.71) education (p=.012). There is significant differences between main scores of DERS-Strategies according to education [F(2-197)=12.397; p=.000]. As a result of the post hoc Tukey test carried out to determine the source of the difference, Strategies scores of those with high school (M=16.40) education were found to be significantly higher than those with bachelor (M=13.04) education (p=.000) and those with graduate and above (M=11.87) education (p=.000). There is significant differences between main scores of DERS-Non acceptance according to education [F(2-197)=8.162; p=.000].

As a result of the post hoc Tukey test carried out to determine the source of the difference, Non acceptance scores of those with high school (M=8.98) education were found to be significantly higher than those with bachelor (M=7.10) education (p=.002) and those with graduate and above (M=6.68) education (p=.003) (Table 4).

Table 4

Main scores of RFQ total, DERS total and its subscales, and ORTO total according to education and One-way ANOVA test

	Education	N	M	SD	F	p	Posthoc Tukey
RFQ - TOTAL	High School and below	82	33.17	9.334	5.067	**.007***	H > G p=.012
	Bachelor	80	29.93	8.155			
	Graduate and above	38	28.21	8.584			
DERS - TOTAL	High School and below	82	51.54	14.610	13.114	**.000***	H > B p=.000 H > G p=.000
	Bachelor	80	42.34	13.821			
	Graduate and above	38	39.58	12.808			
Clarity	High School and below	82	5.73	2.245	6.649	**.002***	H > G p=.002
	Bachelor	80	5.00	1.849			
	Graduate and above	38	4.37	1.651			
Goals	High School and below	82	11.74	3.070	9.221	**.000***	H > B p=.000 H > G p=.006
	Bachelor	80	9.90	2.941			
	Graduate and above	38	9.95	2.760			
Impulse	High School and below	82	8.68	3.868	5.354	**.005***	H > B p=.032 H > G p=.012

	Bachelor	80	7.30	3.231			
	Graduate and above	38	6.71	2.986			
Strategies	High School and below	82	16.40	5.820	12.379	**.000***	H > B p=.000 H > G p=.000
	Bachelor	80	13.04	5.290			
	Graduate and above	38	11.87	4.394			
Non-acceptance	High School and below	82	8.98	3.758	8.162	**.000***	H > B p=.002 H > G p=.003
	Bachelor	80	7.10	3.259			
	Graduate and above	38	6.68	3.402			
ORTO - TOTAL	High School and below	82	28.13	4.306	.016	.984	
	Bachelor	80	28.24	4.252			
	Graduate and above	38	28.11	5.213			

*p<.05 *H: High school, B: Bachelor, G: Graduate*

Independent samples t test showed that there were no significant differences between main scores of RFQ total, DERS total and its subscales, and ORTO total according to education status accept Goals subscale of DERS (Table 5). It is found out that DERS-Goals scores of participants who continue their education (M=11.07) were significantly higher than the participants who do not continue (M=9.91) their education (t=2.260; p=.027).

Table 5

Main scores of RFQ total, DERS total and its subscales, and ORTO total according to education status and Independent samples t test

	Education Status	N	M	SD	t	p
RFQ - TOTAL	Continuous	119	30.28	8.700	-1.257	.210
	Not Continuous	81	31.89	9.188		
DERS - TOTAL	Continuous	119	46.58	14.689	1.153	.250
	Not Continuous	81	44.12	14.924		
Clarity	Continuous	119	5.39	2.124	1.813	.071
	Not Continuous	81	4.86	1.889		
Goals	Continuous	119	11.07	3.052	2.260	**.025***
	Not Continuous	81	10.07	3.049		
Impulse	Continuous	119	7.78	3.648	.128	.898
	Not Continuous	81	7.72	3.399		
Strategies	Continuous	119	14.51	5.768	.961	.338
	Not Continuous	81	13.73	5.507		
Non-acceptance	Continuous	119	7.82	3.661	.158	.874
	Not Continuous	81	7.74	3.587		
ORTO - TOTAL	Continuous	119	28.18	4.652	.057	.954
	Not Continuous	81	28.15	4.157		

*p<.05

The t-test for independent samples showed that there were no significant differences between the main scores of the RFQ total, the DERS total and its subscales, and the ORTO total according to marital status (Table 6).

Table 6

Main scores of RFQ total, DERS total and its subscales, and ORTO total according to marital status and Independent samples t test

	Marital Status	N	M	SD	t	p
RFQ - TOTAL	Single	160	31.46	8.319	2.072	.040
	Married	36	28.11	10.493		
DERS - TOTAL	Single	160	46.61	14.191	1.592	.113
	Married	36	42.28	17.017		
Clarity	Single	160	5.31	1.984	1.188	.236
	Married	36	4.86	2.232		
Goals	Single	160	10.89	3.060	1.823	.070
	Married	36	9.86	3.118		
Impulse	Single	160	7.93	3.522	1.473	.142
	Married	36	6.97	3.566		
Strategies	Single	160	14.58	5.569	1.545	.124
	Married	36	12.97	5.978		
Non-acceptance	Single	160	7.89	3.560	.424	.672
	Married	36	7.61	3.864		
ORTO - TOTAL	Single	160	28.28	4.440	.333	.740
	Married	36	28.00	4.666		

*p<.05

Independent samples t test showed that there is significant difference between main scores of DERS total according to working status (t=-2.787; p=.006). DERS total scores of participants who do not work (M=48.60) was higher than participants who work (M=42.86). There is significant difference between main scores of DERS-Goals according to working status (t=-4.357; p=.000). Goals scores of participants who do not work (M=11.67) was higher than participants who work (M=9.80). There is significant difference between main scores of DERS Strategies according to working status (t=-2.678; p=.008). Strategies scores of participants who do not work (M=15.31) was higher than participants who work (M=13.19) (Table 7).

Table 7

Main scores of RFQ total, DERS total and its subscales, and ORTO total according to working status and Independent samples t test

	Working Status	N	M	SD	t	p
RFQ - TOTAL	Working	105	30.41	9.061	-.868	.387
	Not Working	95	31.51	8.759		
DERS - TOTAL	Working	105	42.86	14.373	-2.787	**.006***
	Not Working	95	48.60	14.746		
Clarity	Working	105	4.98	1.860	-1.439	.152
	Not Working	95	5.40	2.219		
Goals	Working	105	9.80	2.910	-4.357	**.000***
	Not Working	95	11.62	2.997		
Impulse	Working	105	7.43	3.231	-1.362	.175
	Not Working	95	8.12	3.840		
Strategies	Working	105	13.19	5.389	-2.678	**.008***
	Not Working	95	15.31	5.778		

Non acceptance	Working	105	7.46	3.434	-1.369	.172
	Not Working	95	8.16	3.805		
ORTO - TOTAL	Working	105	28.13	4.420	-.122	.903
	Not Working	95	28.21	4.500		

*p<.05

One Way ANOVA revealed that there are no significant differences between the main scores of RFQ total, DERS total and its subscales, and ORTO total according to socioeconomic status (Table 8).

Table 8

Main scores of RFQ total, DERS total and its subscales, and ORTO total according to socioeconomic status and One-way ANOVA test

	SES	N	M	SD	F	p
RFQ - TOTAL	Low	27	33.04	9.622	.933	.395
	Middle	112	30.78	9.076		
	High	61	30.28	8.279		
DERS - TOTAL	Low	27	45.67	14.339	.005	.995
	Middle	112	45.49	14.895		
	High	61	45.72	15.052		
Clarity	Low	27	5.48	2.502	.442	.643
	Middle	112	5.08	1.725		
	High	61	5.23	2.362		
Goals	Low	27	10.67	3.351	.616	.541
	Middle	112	10.86	3.001		
	High	61	10.31	3.128		
Impulse	Low	27	6.93	3.741	1.056	.350

	Middle	112	7.76	3.496		
	High	61	8.11	3.531		
	Low	27	14.33	5.498		
Strategies	Middle	112	14.08	5.598	.052	.950
	High	61	14.34	5.935		
	Low	27	8.26	2.956		
Non acceptance	Middle	112	7.71	3.660	.260	.771
	High	61	7.72	3.852		
	Low	27	27.63	4.448		
ORTO - TOTAL	Middle	112	28.42	4.653	.447	.640
	High	61	27.95	4.084		

*p<.05

3.3. Correlation Analyses

Correlation analyses were conducted to explore the relationships between the study variables (Table 9).

Table 9

Correlation Coefficients between the Study Variables (N=200)

	1	2	3	4	5	6	7	8
1. RFQ - TOTAL	1							
2. DERS - TOTAL	**.646****	1						
3. Clarity	**.536****	.616**	1					
4. Goals	**.470****	.790**	.400**	1				
5. Impulse	**.637****	.799**	.415**	.513**	1			
6. Strategies	**.553****	.936**	.496**	.709**	.683**	1		
7. Non acceptance	**.449****	.820**	.433**	.542**	.548**	.710**	1	

8. ORTO - TOTAL	-.075	-.095	-.057	-.136	-.047	-.061	-.099	1

*p<.05; **p<.01

Pearson correlation analysis revealed that there are significant and positive correlations between total score of RFQ and total score of DERS (r= .646; p<.01) and also between subscales of DERS which are Clarity (r= .536; p<.01), Goals (r= .470; p<.01), Impulse (r= .637; p<.01), Strategies (r= .553; p<.01), and Non acceptance (r= .449; p<.01). Total score of ORTO has neither significant correlation with total score of RFQ nor with total score and subscales of DERS.

3.4 Test of Mediation

To understand the role of difficulties in emotion regulation on relationship between reflective functioning and orthorexia nervosa, bootstrapping method (Bootstrap N=5000; Level of confidence %95) was used in context of mediation analysis. According to Preacher and Hayes (2008) bootstrapping decreases the Type 1 error risk and provides efficient statistical power. The procedure of Model 4 was used in mediation analysis (Figure 1).

To use bootstrap method, any violation of assumptions of linear regression was not found for the data of this research. An analysis of standard residuals was carried out, which showed that the data contained no outliers (Std. Residual Min=-3.188, Std. Residual Max=2.354). Tests to see if the data met the assumption of collinearity indicated that multicollinearity was not a concern (RFQ, Tolerance=.582, VIF=1.717; DERS, Tolerance=.582, VIF=1.717). The data met the assumption of independent errors (Durbin-Watson value =2.165). The histogram of standardized residuals indicated that data contained normally distributed (Mean=-1.97E-16; SD=.995) as illustrated by P-P plot of standardized residuals. The scatterplot of standardized predicted values showed that the data met the assumptions of homogeneity of variance and linearity.

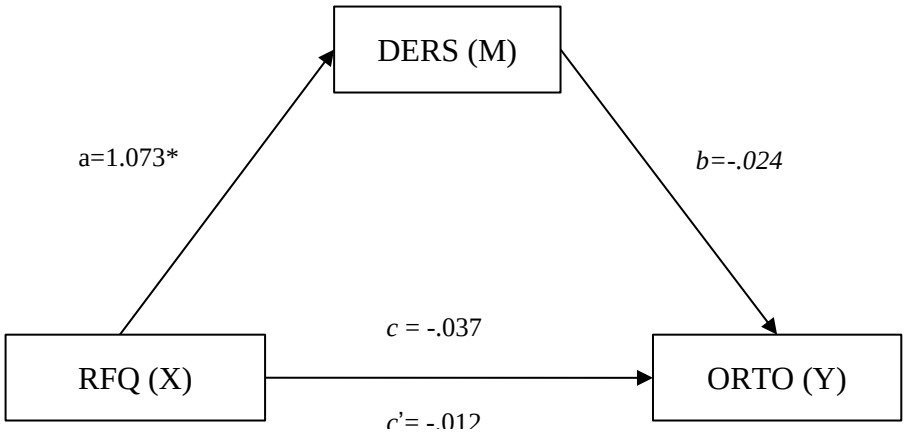

Figure 1. Mediation model for difficulties in emotion regulation on relationship between reflective functioning and orthorexia nervosa *p<.001

The outcome variable for the analyses was orthorexia nervosa. The predictor variable for the analyses was reflective functioning. The mediation variable was difficulty in emotion regulation. The results of mediation analyses revealed that total RFQ scores was significantly predict total scores of DERS (a=1.073, SE=.090; p<.001). It means that individuals who have low reflective functioning are more likely to have high difficulties in emotion regulation. It is revealed that total DERS scores was not significantly predict total scores of ORTO (b=-.024; SE=.028; p>.05). Total effect of RFQ on ORTO was not significant (c=-.037; SE=.035; p > .05). Direct effect of RFQ on ORTO was not significant when the mediator variable (DERS) was included to the analyses (c'=-.012; SE=.046; p>.05). Finally, indirect relationship between RFQ and ORTO via DERS (axb=-.026, SE=.027, 95% Cl [-.0797, .0266]) was not significant (Table 10).

Table 10

Regression analyses for mediation effect of difficulties in emotion regulation on relationship between reflective functioning and orthorexia nervosa

	R	R^2	F	B	B_{se}	t	95%CI
Step 1 RFQ ✍ORTO	.075	.006	1.124	-.037	.035	-1.060	-.107; .032
Step 2	.646	.418	141.955	1.07	.090	11.914	.895; 1.250

RFQ ✍ DERS			*	3		*	
Step 3and 4							
RFQ ✍ ORTO	.097	.009	.932	-.012	.046	-.252	-.103; .080
DERS ✍ORTO				-.024	.028	-.861	-.079; .031

**p<.001*

4.DISCUSSION

The aim of this study is to understand the role of emotion regulation difficulties on relationship between mentalization (reflective functioning) and orthorexia nervosa. The variables of the study are Reflective Functioning, Orthorexia Nervosa and Difficulty in Emotion Regulation. First of all, the relationship between the reflective functioning of the participants and their emotion regulation difficulties was examined. In the next step, the relationship between reflective functioning and orthorexia nervosa was examined. Third the relationship between orthorexia nervosa and difficulties in emotion regulation was examined. Finally, the mediating role of emotion regulation difficulties on the relationship between reflective functioning and orthorexia nervosa was examined. The results are discussed in this order.

4.1 Discussing the Findings on Between Group Comparisons

Firstly, groups comparison analyses were conducted for the variables of the study based on the socio-demographic characteristics of the sample. And this comparison of analysis is discussed in order of analysis.

The current study found that there were no significant differences in the main scores of the RFQ total, the DERS total, its subscales, and the ORTO total between participants based on gender, except for the Goals subscale. The mean of female's goals subscale score was found to be higher than that of male participants. Females were found to have a higher difficulty in emotion regulation than males. This result is consistent with the findings of Saritaş & Gençöz (2015), which showed that females scored higher than males on Goals.

According to the results of the group comparisons, it was found that the participants who graduated from high school had less reflective functioning scores. It is found that RFQ total score high school education level higher than those with graduate and above education. It can be seen that as the level of education increases, reflective functioning capacity also increases. Studies have found that education is related to reflective functioning and the theory of mind (Benbassat & Priel, 2012; Cook et al., 1994 as cited in Benbassat 2020; Stacks et al., 2014). Similarly,

socioeconomic status and theory-of-mind relatedness were reported by some researchers (Jessee et al., 2018) but not by others (Rosso et al., 2015 Still other researchers have found higher empathic adjustment toward others in individuals of low socioeconomic status (Kraus et al., 2010; Stellar et al., 2012). These contradictory observations may be due to the importance of cognitive and emotional-motivational determinants in the achievement of reflective functioning. The observed inconsistencies in the results could be related to a number of factors, including cultural differences, sample size limitations, or gender representation imbalance. Cultural components may contribute to the relationship between education, socioeconomic status, and cognitive ability, as different cultural contexts may influence the development of cognitive and emotional-motivational factors in different ways.

There were no significant differences between main scores ORTO-11 total by education. Similar to the literature, no significant relationship was found between orthorexic tendency and education level (Aksoydan & Camci, 2009; Varga et al., 2014). In a study conducted to develop diagnostic recommendations for orthorexia and to investigate the prevalence of orthorexia nervosa in an Italian sample, in contrast to the current study, there is a higher prevalence of this phenomenon in men and individuals with a lower educational level compared to women and individuals with a higher educational level (Donini et al., 2004). On the other hand, groups with higher levels of postgraduate education exhibited a decreased propensity for orthorexia nervosa compared to groups with different educational backgrounds (Arusoğlu et al., 2008). In the literature, there are contradictory results between orthorexia nervosa and age, gender, and educational level. The reason for this may be sociocultural differences/characteristics between countries and the measurement tools used.

There is a significant difference between main scores of total DERS according to education level. As a result of the emotion regulation scale, the variable of education level shows significant results. The results show that the ability of emotion

regulation is higher with high level of education, while the ability of emotion regulation is lower with high school level of education. The result shows that as the level of education increases, the difficulty in emotion regulation decreases. The study conducted with undergraduate students on the psychometric properties of the Turkish version of difficulties in emotion regulation scale found that they have relatively little difficulty in emotion regulation (Yiğit & Guzey Yiğit, 2019). Moreover, as one of the reasons for this result, it was explained that the reason for the relatively few difficulties in emotion regulation in this study might be that it was conducted in a specific population rather than in the general population. Another research have indicated a correlation between the level of education achieved and the ability to accurately identify emotions (Demenescu et al., 2014; Mill et al., 2009). Studies show that the level of education demonstrated a notable correlation with the ability to recognize emotions (Demenescu et al., 2014; Mill et al., 2009). The present study was conducted in the general population and showed that emotion regulation decreased as the level of education increased. One of the reasons for the different results could be that the current study was conducted in the general population. Besides, in order to understand the relationship between emotion regulation and education level, it is thought that important factors such as the educational strategies of the institutions individuals received education from, sociocultural differences, and personality traits should be taken into consideration.

When examining the relationship between emotion regulation difficulties and educational status, it was found that the DERS-Goals scores of participants who continued their education were significantly higher than those of participants who did not continue their education. No similar results were found in the literature. In addition, to our knowledge, there has not yet been a direct study of the relationship between difficulties in emotion regulation and the difference between participants who continue their education and those who do not The Goals subscale refers to the ability to resist impulsive actions and pursue goals while experiencing emotional distress (Lavender et al. 2015). The present subscale refers to the challenge of pursuing goal-oriented activities while undergoing negative emotional experiences. It is thought that further education may be associated with greater difficulty in performing goal-oriented cognitive and behavioral processes while experiencing

emotional distress. Research on difficulties with emotion regulation has primarily focused on individuals continuing their education, resulting in few studies in the general population (Mohammadi Bytamar et al., 2020; Teixeira et al., 2022; Wilms et al., 2020). Individuals in continuing education may employ maladaptive emotion regulation strategies, such as procrastination, and this goal-oriented emotion regulation strategy that provides short-term relief from negative emotions but prohibit their long-term goal attainment (Mohammadi Bytamar et al., 2020). Because of delaying goals or tasks might leads to the experience of heightened negative emotions, including guilt and anxiety, thereby fostering a greater tendency towards procrastination over a longer period (Fee & Tangney, 2000). It is seemed that those who continue their education have more challenges in effectively managing their emotions associated with goal-oriented tasks, as compared to individuals who do not continue their education. Understanding challenges related to goal-directed emotion regulation is considered crucial for comprehending the experiences of individuals who continue education.

In terms of marital status and socioeconomic status, there were no significant differences between the main scores of RFQ total, DERS total and its subscales, and ORTO. When participants' scores on all scales were compared by marital status and socioeconomic status, there were no differences.

In contrast to the current study, the results of the study provide conclusive evidence that a crucial emotional ability, namely the capacity to regulate behavioral manifestations of emotion, is related to socioeconomic status (Côté et al., 2010). The relationship between socioeconomic status and emotion regulation is ongoing subject. One of the study examine that high socioeconomic status promotes effective emotion regulation, such as lower violence and less hostility (Gallo & Matthews, 2003). Studies also reveal that financial strain in the family may increase conflict and, in turn, conflict in the family is associated with lower ability to regulate emotions (Morris et al., 2007) Another study conducted by Troy et al., (2017) indicate that socioeconomic status may be a particularly powerful moderator of the link between emotion regulation and psychological health because people from different socioeconomic status backgrounds occupy different social environments. The results of the current study do not show a statistically significant relationship between

emotion regulation difficulties and an individual's socioeconomic status. The observed results could be due to several factors related to sample selection, variations in measurement tools, the influence of several interacting variables (such as individual characteristics of participants and cross-cultural differences), and the design of the research study. Further research and analysis that considers multiple factors could lead to a more comprehensive understanding of this subject.

The present study is consistent with previous research findings by showing that marital status did not yield significant differences in orthorexic tendencies (Donini et al., 2005; Obeid et al.,2020; Strahler 2019; Yeşil et al., 2018). The present finding is inconsistent with a study conducted on adult individuals in Italy, which found that singles exhibited higher levels of orthorexia nervosa tendencies compared to others (Ramacciotti et al., 2011).

The current study corroborates prior research findings by demonstrating that there were not any statistically significant differences in orthorexic tendencies based on socioeconomic status. According to the study conducted by Fidan et al., 2007 the relationship between poor diet and social classes cannot solely be attributed to income inequalities. Instead, the researchers suggest that food availability, workplace environments, and cultural food preferences significantly shape dietary patterns (Fidan et al., 2007). Despite Bagci Bosi et al. 2010 investigating a sample characterized by a lower socioeconomic status compared to the sample examined by Fidan et al., 2007, both studies did not observe any significant difference in the prevalence of orthorexia nervosa tendency among medical students. On the other hand, according to a study conducted by Hyrnik et al. (2016), a positive correlation was observed between family income and the likelihood of developing orthorexia nervosa in a sample of individuals from Poland. Additionally, research indicates that orthorexia nervosa exhibits a higher prevalence among individuals with higher income levels, as they possess increased financial resources to procure high-quality foods associated with orthorexia nervosa and enhanced access to information regarding nutritious dietary choices (McComb & Mills, 2019). It is suggested that the reason for the inconsistent results may be due to sample size, differences in measurement tool, and sociocultural differences.

4.2 Discussing the Findings on the Correlation Analyses

Firstly, the results showed that there is a significant correlation between emotion regulation and mentalization. The results of the present study show similarity with the results reported in the existing literature. The process of mentalizing within a secure attachment bond framework typically promotes the acquisition of emotion regulation skills. The effective mentalizing process involves the simultaneous experience of emotions and the cognitive processing of those emotions. This ability is important for regulating one's emotions, both at the individual level and in the context of a family system (Twemlow et al., 2005). The capacity to mentalize develops on the basis of secure attachment interactions during infancy and serves as a fundamental basis for individuals to understand their own internal states and those of others. The result is the capacity to regulate emotions and engage in negotiation rather than struggle (Fonagy et al., 2002). Furthermore, empirical research has demonstrated that individuals with severe psychopathology exhibit a notable decrease in mentalizing abilities when compared to healthy groups (Fonagy et al., 1996 as cited in Schwarzer et al, 2021; Németh et al., 2018). Additionally, certain patient groups exhibit difficulties in emotional regulation (Chapman et al, 2008; Salsman & Linehan, 2012).

According to Allen et al. (2013), it is crucial to possess the capacity to identify, express, and regulate behaviors and emotions in connection with our desires, cognitions, and affective states to establish and sustain effective interpersonal communication. Mentalization is crucial in establishing and maintaining positive relationships, promoting empathy, shared comprehension, and efficient social interactions. Euler et al. (2019) conducted a study that revealed that interpersonal difficulties were predicted by both mentalization and emotion regulation in patients with borderline personality disorder. The findings of the study showed that mentalization deficits do not have a direct effect on interpersonal difficulties, however, they do have an indirect effect on interpersonal problems through their association with emotion regulation difficulties (Euler et al., 2019). This suggests that mentalization has a direct effect on the regulation of emotions, which can lead to interpersonal problems.

Schwarzer et al. (2021) state that mentalization is crucial in regulating emotional responses. Theoretical frameworks suggest that affect regulation is a precursor to mentalization and can also be enhanced due to mentalization (Fonagy & Allison, 2013; Fonagy et al., 2002, p.26). The mentalization process can aid in advancing the self and self-agency, which may serve as a protective measure against emotional arousal caused by stress.

Additionally, a reduced ability to recognize and acknowledge others' emotions might hinder the ability to connect with others and maintain relationships by making it difficult for individuals to respond appropriately to others' emotional manifestations (Brewer et al., 2015). Individuals diagnosed with eating disorders frequently exhibit a reduced capacity for mentalizing goes through an increased challenge in distinguishing between physical and emotional sensations, as well as difficulties in identifying their own experiences from those of others (Kuipers & Bekker, 2012; Skårderud 2007; Skårderud & Fonagy, 2012). Moreover, they tend to attribute causal relationships to both themselves and interpersonal encounters.

According to a study by Rothschild-Yakar et al. (2013), there is a correlation between higher levels of reflective functioning and lower levels of eating disorder symptoms. In addition, the study found that higher levels of reflective functioning indirectly lead to lower levels of eating disorder symptoms by reducing distress (Rothschild-Yakar et al., 2013). The capacity for reflective functioning may act as a maintaining component to reduce eating disorder symptoms.

Secondly, there is no significant correlation between mentalization and orthorexia nervosa. Empirical evidence elucidating a direct connection between mentalization and orthorexia nervosa is sparse. Nonetheless, theoretical frameworks present worthwhile insights into potential links between these concepts. Mentalization, as outlined by Fonagy et al. (2002), is the capacity to perceive and interpret our own and others' mental states, which encapsulates the identification and empathic comprehension of the thoughts, feelings, and intentions of oneself and others. Contrarily, orthorexia nervosa is characterized by an excessive preoccupation with eating healthful foods, accompanied by a compulsion to strictly follow dietary rules (Cartwright, 2004; Dittmar, 2009; Varga et al., 2013).

The connection between mentalization and eating disorders has been a significant focal point of investigation. Mentalization is considered the cognitive skill needed to comprehend and interpret our own and others' mental processes, involving cognitive, emotional, and intentional aspects like thoughts, emotions, and motives. As suggested by Fonagy et al. (2002), emotional intelligence is instrumental in interpersonal relationships, self-awareness, and self-regulation.

Numerous scholarly inquiries have been conducted into the relationship between mentalization and eating disorders, attempting to clarify the possible mechanisms underpinning these disorders (Gagliardini et al., 2020; Jewell et al.,2021; Rothschild-Yakar et al., 2019; Pedersen et al., 2015). The body of research suggests that mentalization abilities are often diminished in those with eating disorders, such as anorexia nervosa, bulimia nervosa, and binge eating disorder, compared to those without such disorders (Rothschild-Yakar et al., 2019; Simonsen et al., 2020). These deficits become evident as barriers in understanding and interpreting one's own and others' cognitive processes, leading to struggles with comprehending emotions, motivations, and social interactions (Gagliardini et al., 2020). Furthermore, the study findings show that failure in mentalizing, particularly a poor understanding of mental states, is strongly associated with an increased risk of developing eating disorders (Quattropani et al., 2022). The research has shown that individuals diagnosed with eating disorders exhibit a higher prevalence of insecure attachment, reduced levels of mentalizing, and more significant challenges in their relationships with their parents compared to individuals without such disorders (Rothschild-Yakar et al., 2010 as cited in Redondo & Luyten, 2018). The research by Redondo and Luyten (2018) proved that decreased attention to internal states was an intermediate in the association between eating disorder symptoms and insecure attachment. Therefore, mentalizing has the potential to be a crucial element in the development of eating disorders (Simonsen et al., 2020; Skarderud & Fonagy, 2012).

In addition, it has been suggested that a lack of mentalization could play a crucial role in the initiation and perpetuation of irregular eating behaviors. Those suffering from eating disorders may face difficulties, particularly in understanding their body image and the emotional and psychological factors driving their eating behaviors (Blodgett Salafia et al., 2015). Such difficulties can potentially cultivate a

distorted cognitive representation of food, weight, and body shape, leading to a heightened focus on physical appearance and an unhealthy relationship with dietary habits.

Deficits in mentalization might influence the development of orthorexia nervosa. The inability to accurately understand and define one's own emotions and thoughts can result in inflexible cognitive patterns, a fixed mindset, and a strong desire for regulation concerning food and body image (Golan&Mozeikov, 2021; Koven & Senbonmatsu, 2013; Oldershaw et al.,2019). The emergence and continuation of orthorexic tendencies may be influenced by cognitive and affective factors.

The capacity for mentalization, which pertains to the comprehension and interpretation of one's own and others' mental states, could potentially bear consequences for self-centeredness and narcissism (Choi-Kain et al., 2022). Individuals exhibiting self-centered or narcissistic traits may be at a heightened risk of developing orthorexic tendencies owing to their preoccupation with self-image, physical appearance, and external confirmation (Barnes & Caltabiano, 2017; Martinovic et al., 2022). The preoccupation with self may potentially lead to an increased focus on following stringent dietary regulations and striving for a perfect physique (Dittmar, 2009; Eriksson et al., 2008). Additionally, narcissistic characteristics may also have an impact on the appearance of orthorexia nervosa. Individuals demonstrating orthorexic tendencies may display self-centered behaviors, a sense of superiority concerning their dietary choices, and an increased focus on their own appearance and perceived control over their bodies (Bóna et al.,2021; Oberlo et al.,2017; Tabri et al., 2022). The presence of narcissistic traits may exacerbate challenges in mentalization, as the individual's attention becomes excessively self-centered, possibly hindering their capacity to understand and interpret the mental states of others and to empathize with them (Choi-Kain et al., 2022).

Orthorexia neurosis has been considered an eating attitude that starts as a healthy eating attitude and then causes compelling emotions and behaviors in the person's daily life. Although orthorexia nervosa is a new eating behavior, it shows symptoms similar to other eating attitudes in many ways, even if the studies are limited. Although mentalization is a new concept in the literature, its relation with

other eating disorders has been explained. Based on the relationship between mentalization and other eating disorders, this study aimed to investigate the relationship between mentalization and orthorexia nervosa. The result of the research showed that there is no direct relationship between reflective functioning and orthorexia.

Finally, there is no significant relationship between the difficulty in emotion regulation scores of the participants and their orthorexia nervosa scores. This result obtained from the study was different from the literature findings.

Difficulty in emotion regulation has been stated as a fundamental aspect of various psychopathologies, and it has been stated to affect psychosocial functioning. It has been stated that one of the underlying causes of eating disorders is related to difficulties in emotion regulation (Svaldi et al., 2012). When the studies dealing with the relationship between emotion dysregulation and orthorexia nervosa are examined, it is seen that dysregulation of emotion is considered a risk factor for the emergence of orthorexia nervosa (Obeid et al., 2021; Vuillier et al., 2020). This is because obsessive attitudes and behaviors toward healthy eating in orthorexia nervosa aim to provide a sense of control (Vuillier, et al., 2020). It is seen that the current study's findings diverge from the findings contained in the literature. According to previous studies orthorexic tendencies are defined by eating behaviors that allow individuals to be more in control and may be developed as a coping mechanism. Another study (2020) revealed a significant relationship between difficulties with identifying and regulating emotions and the emergence of symptoms associated with orthorexia nervosa. The study revealed that individuals showing high levels of orthorexic tendencies encountered difficulties recognizing and acknowledging their emotions, regulating their impulses, pursuing goal-oriented actions, and establishing effective coping mechanisms during times of distress, contrary to those with low orthorexic tendencies (Vuillier et al., 2020). As seen in other eating disorders, individuals with orthorexia nervosa use their control over food as a means of emotion regulation. In a recent investigation study by Costanzo et al. (2020) aimed at comprehending the mechanisms that underlie the psychopathology of orthorexia nervosa, it was observed that individuals with this condition exhibited considerably higher levels of anxiety, somatization and paranoid thoughts in comparison to healthy eating group. The notion

is that the symptoms of orthorexia nervosa could potentially function as maladaptive coping mechanisms for regulating emotional distress (Costanzo et al., 2022). Regardless of the limited research on the association between difficulties with regulating emotions and orthorexia nervosa, it is claimed that similar correlations can be established with regards to eating psychopathology. Orthorexia nervosa and eating disorders (especially anorexia and avoidant restrictive food intake disorder) share similarities in terms of restrictive dieting, perfectionism, neurotic personality characteristics and an extreme desire for control, as well as rigidity in behavior and rituals associated to food preparation (Dell'Osso et al., 2016). Considering the relationship of difficulty in emotion regulation with eating disorder, it is thought that the same mechanism may be valid for orthorexia nervosa. The study conducted by Greville-Harris and colleagues (2019) conducted a qualitative analysis of 15 female bloggers who identified themselves with orthorexia nervosa. The study's findings indicated that the participants utilized coping mechanisms such as implementing strict dietary recommendations for healthy eating and trying to maintain control (Greville-Harris et al., 2019).

4.3 Discussing the Finding of the Mediation analysis

The hypothesis was emotion regulation will mediate the relationship between individuals' reflective functioning capacity and orthorexia nervosa. However, the hypothesis which indicated that difficulties in emotion regulation mediate the relationship between reflective functioning and orthorexia nervosa was not supported. In other words, it was found that emotion regulation difficulties did not mediate the relationship between reflective functioning and orthorexia nervosa, suggesting that reflective functioning did not have a significant effect on orthorexia nervosa.

To the best of our knowledge, there is an absence of research investigating the potential direct or indirect relationship between reflective functioning and orthorexia nervosa. The relationship between mentalization and emotion regulation is an ongoing subject of discussion in literature, with numerous studies and research indicating a significant association between the two concepts (Innamorati et al., 2017; Schwarzer et al., 2021; Sharp et al., 2011 Twemlow et al., 2005).

Hence, it appears essential that one thinks about emotion regulation as a potential confounding factor while investigating reflective functioning (Fonagy & Target, 1997). A comprehensive review has revealed that individuals diagnosed with eating disorders often struggle with understanding and empathizing with the viewpoints of others. Additionally, these individuals display diminished capabilities to perceive and interpret internal cues, like hunger, and experience issues articulating their mental states (Caglar-Nazali et al., 2014). Such findings suggest a significant disturbance in the mentalization abilities amongst individuals dealing with eating disorders. Also, different internal process, including self-regulation, mentalization could be very effective in eating disorder development (Golan & Mozeikov, 2021). Here, it is important to note that all these studies capture anorexia nervosa, bulimia nervosa and binge eating disorder as eating disorder. Orthorexia nervosa has not been included in recent studies. It may have different underlying mechanisms in context of self-agency. This could be an explanation for the finding in this study. More empirical studies are required to shed light on the connection between mentalization, orthorexia nervosa, and emotional regulation difficulties.

Research have highlighted the crucial role of mentalization in decoding personal and collective cognitive states (Choi-Kain et al., 2008; Fonagy & Target, 2006). Studies have found mentalization impairments amongst individuals suffering from eating disorders, such as anorexia nervosa and bulimia nervosa (Sacchetti et al., 2019; Skårderud, 2007). These shortcomings can appear as issues in accurately identifying and understanding emotions, cognitions, and motivations, leading to limited cognitive flexibility and compromised social interactions. Investigations into orthorexia nervosa have uncovered shared traits with other eating disorders, such as obsession with physical appearance, perfectionism, a desire for thinness, distrust in interpersonal relationships, and difficulties in emotion regulation (Dunn & Bratman, 2016; Vuillier et al., 2020). However, mentalization and emotion regulation did not predict orthorexia nervosa. It could be related to timing of study. This study was conducted after pandemic. Here, eating behavior related to orthorexia could be associated to other factors such as health concerns rather than perfectionism, emotion regulation or social relationships.

Impaired mentalization can further contribute to challenges in emotional regulation. This is due to the fact that the ability to accurately perceive and understand one's emotions is vital for effective emotional regulation (Fonagy et al., 2002). Difficulties regulating emotions have been consistently reported in people who suffer from eating disorders (Harrison et al.,2010; Lavender et al., 2015). According to Svaldi et al. (2012), individuals experiencing emotion dysregulation can turn to maladaptive behaviors, such as inflexible dietary rules, as a way to regulate emotional distress. Although a limited amount of research specifically explores the relationship between mentalization, orthorexia nervosa, and difficulties in emotion regulation, specific investigations conducted on eating disorders related to these constructs offer some indications. Lavender et al. (2015) conducted a study that showed that enhanced eating disorder psychopathology in individuals with anorexia nervosa and bulimia nervosa was linked with problems in mentalization and difficulties in emotion regulation.

It is important to recognize that the interplay between mentalization, orthorexia nervosa, and emotion regulation challenges is likely complex and influenced by a variety of factors. It is important to consider elements such as cultural influences, individual variances, and the potential for co-existing conditions when examining this relationship (Alarcón, 2009;Putul et al., 2018)). Further research is needed to uncover the precise mechanisms that link mentalization, orthorexia nervosa, and emotion regulation difficulties. Conducting longitudinal studies that track the progression of mentalization and its impact on relationships with others and emotion regulation would greatly expand this area of research. In addition, therapeutic strategies aimed at improving mentalization and emotion regulation skills could be beneficial for individuals with orthorexia nervosa.

4.4 Limitations of the Study and Recommendation for Further Studies

One primary limitation concerns the use of only self-reported data from participants, despite using established and standardized instruments for collecting data. The sample of the study could not reach a clinical sample since orthorexia

nervosa has no published diagnostic criteria yet. It is possible that the current study group did not include a clinically identified group with an eating problem and that the measures were employed were based on self-report may have caused to the participants' biased responses and defensive or self-concealment attitude.

Another possible limitation relates to population-based characteristics. In reviewing the relevant literature, certain groups were found to be more affected by orthorexia nervosa than others. Medical students (Strand, 2004), medical practitioners (Fidan et al., 2010), performing artists (Aksoydan & Camcı, 2009), nutritionists (Alvarenga, 2012; Kinzl et al., 2006), and athletes (Eriksson et al., 2008) are among the at-risk groups. However, the current study examined the general population, and there may be a limitation because it did not examine a population with a specific risk factor. The likely limitation of the study relates to the use of a non-probability sampling method. This approach imposes some limitations on the distribution of participant characteristics in terms of demographic variation and the degree to which the sample is representative of the population.

Given that orthorexia nervosa is not clinically recognized as an eating disorder, it is acknowledged that studies examining the relationship between emotional dysregulation and eating disorders cannot be universally applied to orthorexia nervosa, although they may provide perspective. Therefore, it is thought that the predictive effect of emotion regulation difficulties on orthorexia nervosa should be addressed in future studies. By focusing on a clinical sample of individuals who meet the "criteria" for orthorexia nervosa, future research may expand this study. The research base on orthorexia nervosa will also expand through studies with a larger and more heterogeneous sample.

Although orthorexia nervosa is a new and under-researched concept in the literature, there are studies with significant results regarding difficulty in emotion regulation. Emotion regulation and its relationship with eating disorders are two topics that have been studied for a long time and are highly related. A risk factor for orthorexia nervosa, which is on a scale shifting from a healthy eating attitude to pathology, is assumed to be difficulty in emotion regulation, which is highly associated with eating disorders. Consequently, it is suggested that future research

should focus more on the predicted impact of difficulty in emotion regulation on orthorexia nervosa.

4.5.Clinical Implications

In understanding and treating orthorexia nervosa, it may be essential to identify and work on mentalization deficits and difficulties in emotion regulation. Therapists should strive to assist patients in developing healthier emotional coping strategies. Moreover, developing mentalization skills can lead to an enriched understanding of. others' perspectives, fostering empathy and improving communication skills. This may facilitate healthier interpersonal interactions (Fonagy & Luyten, 2016).

The clinical significance of these findings emphasizes the need to incorporate mentalization-based interventions in the evaluation and treatment of orthorexia nervosa. Analyzing mentalization skills can shed light on a person's overall psychopathology, their ability to control emotions, and their effectiveness in interpersonal interactions. By addressing mentalization shortcomings, healthcare professionals can aid individuals in comprehending their own and others' mental states more effectively, fostering enhanced empathy and communication skills (Allen & Fonagy, 2006).

Moreover, dealing with emotion regulation issues is a pivotal element in managing orthorexia nervosa. Treatment approaches should prioritize imparting healthier emotional coping mechanisms and promoting more adaptive emotional regulation strategies **(**Bonanno & Burton, 2013; John & Gross, 2004). By boosting mentalization skills and advocating effective emotional regulation, individuals with orthorexia nervosa can cultivate healthier perceptions of food, body image, and interpersonal relationships.

An all-encompassing approach addressing both psychological and physical aspects of orthorexia nervosa, in conjunction with mentalization deficits and challenges in emotional regulation, is advised. By understanding the integral role of mentalization in the progression and sustainability of orthorexia nervosa, healthcare professionals can deliver specialized interventions that tackle the root

psychopathology. This fosters improved overall well-being and functionality in individuals coping with this disorder. Additional research in this field is crucial to broaden our comprehension of the connection between mentalization and orthorexia nervosa and to pave the way for more effective treatment methodologies.

Comprehending mentalization and emotion regulation in individuals with orthorexia nervosa is crucial in unveiling the intrinsic mechanisms of this eating disorder. Individuals suffering from orthorexia nervosa may resort to extreme, obsessive dietary practices as a means of coping with deficient emotion regulation and reestablishing a sense of control (Vuillier et al., 2020). This conduct is particularly noticeable when individuals confront distress or negative emotions and lack cognizance of alternative coping strategies (Vuillier et al., 2020). Associations between control perceptions, guilt, and the stigma associated with orthorexia nervosa are also established (Nevin & Vartanian 2017). The investigation into the interaction of mentalization and emotion regulation can yield important insights into the longitudinal impact of orthorexia nervosa on individuals, taking into account factors such as control needs, feelings of superiority, and obsessions, as well as their outcomes.

Operationalized as reflective functioning, mentalization significantly contributes to understanding one's own and others' mental states encompassing emotions, intentions, thoughts, beliefs, and desires (Fonagy et al., 2002). Applying mentalization to orthorexic individuals enables researchers to better comprehend their behavioral patterns, thought processes, and perceptions of others' intentions and emotions. This exploration assists in deciphering the foundational mechanisms of orthorexia nervosa. Concurrently, the analysis of emotion regulation is vital in understanding the ability of orthorexic individuals to control their emotional responses. Strict dietary rules often characterize individuals with orthorexia nervosa, potentially magnifying feelings of control, superiority, and obsessive thoughts (Bratman, 2017; Hayes et al., 2017; Varga et al., 2013).

Incorporating mentalization and emotion regulation into the orthorexia nervosa discourse can yield a holistic understanding of this eating disorder. This approach allows individuals to introspect their cognitive patterns, emotional reactions, and mental processes, thereby aiding the creation of effective interventions (Allen &

Fonagy 2006). By comprehending and altering these processes, individuals can foster a healthier perspective on nutrition, safeguarding themselves from the detrimental effects associated with orthorexia nervosa. Given the limited existing literature exploring the relationship between mentalization and orthorexia nervosa, the significance of the current study is underscored. It broadens our comprehension of orthorexia nervosa by examining the potential influence of mentalization on the disorder's onset and continuity.

In conclusion, the clinical implications related to mentalization and orthorexia nervosa underline the importance of assessing mentalization capacity as a core element of its diagnosis, treatment, and assessment. A thorough, integrated approach that includes mentalization-based interventions and encourages regulatory flexibility is crucial to treatment outcomes (Robinson et al., 2019; Zeeck et al., 2021). This approach improves patients' mentalizing abilities, emotion regulation, and enhances their overall psychological health and functioning. Continued research in this area will undoubtedly refine and enhance therapeutic interventions for orthorexia nervosa, leading to improved mental health outcomes for individuals suffering from this disorder.

4.6 Conclusion

The result of the study shows that difficulty in emotion regulation did not have a mediating effect in the relationship between reflective functioning and orthorexia nervosa. Although reflective functioning had a positive and statistically significant relationship with emotion regulation difficulties, it is found that there is no relationship between reflective functioning and orthorexia nervosa via difficulty in emotion regulation. In the study, orthorexia was no direct or indirect relationship to each difficulty in emotion regulation and reflective functioning. By focusing on a clinical sample of individuals meeting the "criteria" for orthorexia nervosa, future research may be expanded this study. The research base on orthorexia nervosa should also expand with studies involving more extensive and heterogeneous samples.

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Appendix A: Informed Consent Form

Bilgilendirilmiş Onam Formu

Sayın katılımcı,

Bu araştırma Dr. Öğr. Üyesi Seray Akça danışmanlığında, Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Kader Tarhan tarafından, tez çalışması kapsamında yürütülmektedir. Çalışmanın amacı, yeme tutumlarının, kendini ve başkalarını anlamaya yönelik güçlükler ve duygu düzenleme ile olan ilişkisini incelemektir.

Görüşmenin amacına ulaşması için sizden beklenen, rahat hissettiğiniz sürece, bütün sorulara eksiksiz olarak ve içtenlikle cevap vermenizdir.

Bu görüşmenin hiçbir aşamasında, kimlik bilgileriniz sorulmayacaktır. Yanıtlar araştırmacılar dışında kimseyle paylaşılmayacak ve edilen tüm bilgiler anonim olarak değerlendirilecektir.

Tüm araştırma verileri güvenli bir şekilde saklanacak ve yalnızca bilimsel amaçlarla kullanılacaktır. Tüm görüşme yaklaşık olarak 15-20 dakika sürmektedir. Soruların doğru veya yanlış bir cevabı bulunmamaktadır.

Çalışmaya katılım gönüllülük esasına dayanmaktadır. Görüşme sorularının herhangi bir risk taşıdığı öngörülmemiştir. Bir rahatsızlık hissetmeniz durumunda herhangi bir sebep belirtmeksizin görüşmeyi bitirebilirsiniz. Araştırmadan çekildiğiniz takdirde, iletmiş olduğunuz bilgiler imha edilecek ve değerlendirilmeyecektir.

Araştırma ile ilgili şimdi veya sonra daha fazla bilgiye ihtiyaç duyarsanız

Yukarıdaki açıklamayı okudum. Verilen bilgiler doğrultusunda çalışmaya katılmayı kabul ediyorum. Çalışmayı istediğim zaman bırakabileceğimi biliyorum. İletmiş olduğum bilgilerin anonim olarak bilimsel yayımlarda kullanılmasına izin veriyorum.

Appendix B: Sociodemographic Form

1. Yaşınız: _____

2. Cinsiyetiniz:

3. Eğitim durumunuz:

( ) Lise ( ) Üniversite ( ) Yüksek Lisans ( ) Doktora ve üstü

4. Mesleğiniz: _____

5.En son mezun olduğunuz okul?

( )Ortaokul ( ) Lise ( ) Lisans ( ) Yüksek Lisans ( ) Doktora

6. Eğitiminize devam ediyor musunuz?

( )Evet ( ) Hayır

7. Medeni Durumunuz:

( )Bekar ( )Evli ( )Boşanmış ( )Dul

8.Çalışıyor musunuz?

( )Evet ( ) Hayır

9. Mesleğiniz nedir?

10. Ekonomik durumunuz:

( ) Alt ( ) Orta Alt ( ) Orta ( ) Orta Üst ( ) Üst

Appendix C: Reflective Functioning Questionnaire (RFQ)- Short Form

Lütfen aşağıdaki cümleleri dikkatlice okuyunuz. Her bir cümle için, cümleye ne kadar katıldığınızı ifade etmek üzere 1 ile 7 arasında bir numara seçip cümlenin yanına yazınız. Cümleler üzerinde çok fazla düşünmeyin- ilk tepkiniz genellikle en iyisidir. Teşekkür ederiz.

1'den 7'ye kadar olan aşağıdaki ölçeği kullanın:

Kesinlikle Katılmıyorum	1	2	3	4	5	6	7	Kesinlikle Katılıyorum

1. İnsanların düşünceleri benim için bir bilinmezdir.
2. Neyi neden yaptığımı her zaman bilmem.
3. Sinirlendiğimde, neden söylediğimi gerçekten bilmediğim şeyler söylerim.
4. Sinirlendiğimde, sonradan pişman olacağım şeyler söylerim.
5. Eğer güvensiz hissedersem, diğerlerini sinirlendirecek şekilde davranırım.
6. Bazen neden yaptığımı gerçekten bilmediğim şeyler yaparım.
7. Ne hissettiğimi her zaman bilirim.
8. Güçlü duygular genellikle düşüncelerimi bulanıklaştırır.

Appendix D: The Orto-11 Scale

	Her zaman	Sık sık	Bazen	Hiç bir zaman
1- Son üç ay içerisinde tükettiğiniz besinleri düşünmek endişelenmenize neden oldu mu?	1	2	3	4
2- Sağlığınızla ilgili endişeleriniz besin seçiminizi etkiler mi?	1	2	3	4
3- Yiyeceklerinizin sağlıklı olması sizin için lezzetinden daha mı önemlidir?	1	2	3	4
4- Daha sağlıklı besinlere daha fazla para harcar mısınız?	1	2	3	4
5- Sağlıklı beslenme ile ilgili düşünceler sizi günde üç saatten fazla meşgul eder mi?	1	2	3	4
6- Sağlıksız olduğunu düşündüğünüz besinleri yediğiniz olur mu?	4	3	2	1
7- Besinler içerisinde sadece sağlıklı olanlarını tüketmek kendinize olan güveninizi artırır mı?	1	2	3	4
8- Sağlıklı beslenmek yaşam tarzınızı değiştirir mi? (dışarıda yeme, arkadaşlarla yemek gibi)	1	2	3	4
9- Sağlıklı beslenmenin dış görünümünüzü daha iyi hale getirebileceğini düşünür müsünüz?	1	2	3	4

10- Sağlıksız beslendiğinizde kendinizi suçlu hisseder misiniz?	2	4	3	1
11- Süpermarketlerde sağlıksız besinlerin de satıldığını düşünür müsünüz?	1	2	3	4

Appendix E: DIFFICULTIES IN EMOTION REGULATION SCALE-BRIEF FORM (DERS-16)

Duygu Düzenleme Güçlüğü Ölçeği-Kısa Form (DDGÖ-16)

Aşağıdaki ifadelerin size ne sıklıkla uyduğunu, her ifadenin yanında yer alan 5 dereceli ölçek üzerinden değerlendiriniz. Her bir ifadenin altındaki 5 noktalı ölçekten, size uygunluk yüzdesini de dikkate alarak, yalnızca bir tek rakamı yuvarlak içine alarak işaretleyiniz.

	Hemen hemen hiç (% 0-% 10	Bazen (% 11-% 35)	Yaklaşık Yarı yarıya (% 36-% 65)	Çoğu zaman (% 66-% 90)	Hemen hemen her zaman (% 91-% 100)
1. Duygularıma bir anlam vermekte zorlanırım.					
2. Ne hissettiğim konusunda karmaşa yaşarım.					
3. Kendimi kötü hissettiğimde işlerimi bitirmekte zorlanırım.					
4. Kendimi kötü hissettiğimde kontrolden çıkarım.					
5. Kendimi kötü hissettiğimde uzun süre böyle kalacağına inanırım.					
6. Kendimi kötü hissetmenin yoğun depresif duyguyla sonuçlanacağına inanırım.					
7. Kendimi kötü hissederken başka şeylere odaklanmakta zorlanırım.					
8. Kendimi kötü hissederken kontrolden çıktığım korkusu yaşarım.					
9. Kendimi kötü hissettiğimde bu duygumdan dolayı kendimden utanırım.					
10. Kendimi kötü hissettiğimde zayıf biri olduğum duygusuna kapılırım.					
11. Kendimi kötü hissettiğimde davranışlarımı kontrol etmekte zorlanırım.					
12. Kendimi kötü hissettiğimde daha iyi hissetmem için yapabileceğim hiçbir şey olmadığına inanırım.					
13. Kendimi kötü hissettiğimde böyle hissettiğim için kendimden rahatsız olurum.					
14. Kendimi kötü hissettiğimde kendimle ilgili olarak çok fazla endişelenmeye başlarım.					
15. Kendimi kötü hissettiğimde başka bir şey düşünmekte zorlanırım.					
16. Kendimi kötü hissettiğimde duygularım dayanılmaz olur.					

Appendix E: DIFFICULTIES IN EMOTION REGULATION SCALE-BRIEF FORM (DERS-16)

Appendix E: Debriefing Form

Katılım Sonrası Bilgilendirme Formu

Bu araştırma Dr. Öğr. Üyesi Seray Akça danışmanlığında, Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Kader Tarhan tarafından, tez çalışması kapsamında yürütülmektedir. Bu çalışmada kişisel deneyimleriniz ve yeme tutumlarınız arasındaki ilişkiye bakılacaktır. Araştırma ile ilgili bir sorunuz olduğunda, Psk.