

THE RELATIONSHIP BETWEEN HELICOPTER PARENTING AND EATING
DISORDER SYMPTOMS IN UNIVERSITY STUDENTS: THE ROLES OF
PARENTAL EMOTIONAL AVAILABILITY AND
EMOTION REGULATION DIFFICULTY

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ABSTRACT

THE RELATIONSHIP BETWEEN HELICOPTER PARENTING AND EATING DISORDER SYMPTOMS IN UNIVERSITY STUDENTS: THE ROLES OF PARENTAL EMOTIONAL AVAILABILITY AND EMOTION REGULATION DIFFICULTY

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This study investigates the relationship between helicopter parenting (HP) and eating disorder symptoms severity, with a focus on the mediating roles of parental emotional availability (EA) and emotion regulation difficulty among a sample of 303 Turkish university students. Quantitative research utilizing online survey was employed. Bivariate correlations and mediation analyses were conducted to analyze the data. The findings revealed an indirect positive association between maternal HP and eating disorder symptoms severity through emotion regulation difficulty. Additionally, paternal HP demonstrated a negative relationship with eating disorder symptoms severity through serial mediation of paternal EA and emotion regulation difficulty. There was a positive association between paternal HP and paternal EA, while the association between paternal EA and emotion regulation difficulty was negative. The results contribute to the growing body of research on the effects of HP on university students and emphasize the importance of considering both parental EA and emotion regulation difficulty in understanding the impact of HP on eating disorders. The findings have implications for parents and mental health professionals in developing interventions and parental education programs to mitigate the potential negative impact of helicopter parenting. Future research directions and limitations are also discussed.

Keywords: Helicopter Parenting, Eating Disorders, Parental Emotional Availability, Emotion Regulation Difficulty

ÖZ

HELİKOPTER EBEVEYNLİK VE ÜNİVERSİTE ÖĞRENCİLERİNDE YEME BOZUKLUĞU BELİRTİLERİ ARASINDAKİ İLİŞKİ: EBEVEYN DUYGUSAL ERİŞİLEBİLİRLİĞİNİN VE DUYGU DÜZENLEME GÜÇLÜĞÜNÜN ROLLERİ

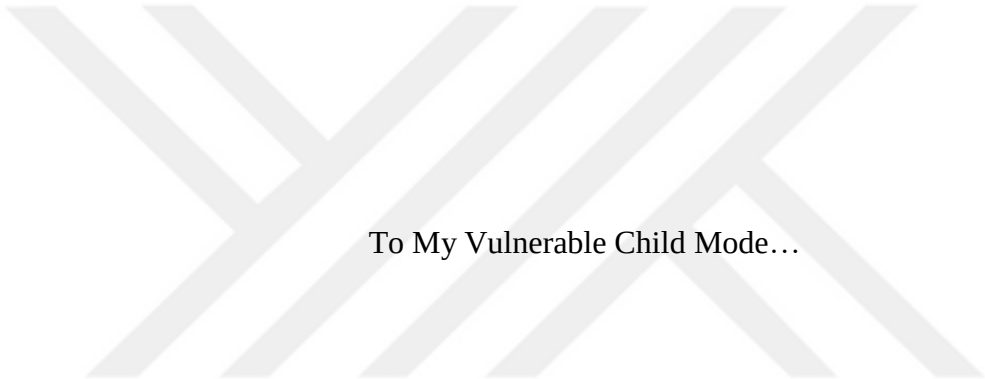
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Bu çalışma, helikopter ebeveynlik (HE) ile yeme bozukluğu belirtileri şiddeti arasındaki ilişkiye ve bu ilişkide anne-baba duygusal erişilebilirliği (DE) ile çocuğun duygu düzenleme güçlüğü (DDG) aracılık rollerine odaklanmaktadır. Çalışmanın örneklemini, 303 üniversite öğrencisinden oluşmaktadır. Veri toplama yöntemi olarak çevrimiçi anket kullanılmıştır. Değişkenler arasındaki ilişkiler ikili korelasyon ve aracılık analizleri ile incelenmiştir. Bulgular, annenin HE ile yeme bozukluğu belirtileri şiddeti arasında pozitif bir ilişkinin, çocuğun DDG aracılığıyla var olduğunu göstermektedir. Ayrıca, babanın DE ve çocuğun DDG seri aracılığıyla, babanın HE ve yeme bozukluğu belirtileri şiddeti arasında negatif yönlü bir ilişki ortaya çıkmıştır. Babanın HE ile DE arasında pozitif bir ilişki bulunurken, babanın DE ile çocuğun DDG arasında negatif bir ilişki bulunmuştur. Sonuçlar, helikopter ebeveynliğin üniversite öğrencileri üzerindeki etkileri konusunda yapılan araştırmalara katkı sağlamakta ve helikopter ebeveynliğin yeme bozukluklarına etkisini anlamak için ebeveynlerin duygusal erişilebilirliğini ve çocuğun duygu düzenleme güçlüğüne dikkate almanın önemini vurgulamaktadır. Bulgular, helikopter ebeveynliğin potansiyel olumsuz etkisini azaltmaya yönelik müdahaleler ve ebeveyn eğitim programları geliştirme konusunda ebeveynlere ve ruh sağlığı uzmanlarına ipuçları sunmaktadır. Ayrıca, bu çalışmanın güçlü yönleri, sınırlılıkları ve gelecekteki araştırmalar için öneriler tartışılmaktadır.

Anahtar Kelimeler: Helikopter Ebeveynlik, Yeme Bozuklukları, Ebeveyn Duygusal Erişilebilirliği, Duygu Düzenleme Güçlüğü



To My Vulnerable Child Mode...

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LIST OF ABBREVIATIONS

A-AN	: Atypical Anorexia Nervosa
ACT	: Acceptance and Commitment Therapy
ADHD	: Attention Deficit Hyperactivity Disorder
AN	: Anorexia Nervosa
AN-BP	: Anorexia Nervosa Binge-Eating/Purging Type
AN-R	: Anorexia Nervosa Restricting Type
APA	: American Psychological Association
ARFID	: Avoidant/Restrictive Food Intake Disorder
ASB	: Autonomy Supportive Behaviors
ASD	: Autism Spectrum Disorder
BED	: Binge Eating Disorder
BMI	: Body Mass Index
BN	: Bulimia Nervosa
BPD	: Borderline Personality Disorder
CDC	: Centers for Disease Control and Prevention
DE	: Disordered Eating
DERS-16	: The Difficulties in Emotion Regulation Scale-Brief Form
DSM-5	: The Fifth Version of Diagnostic and Statistical Manual of Mental Disorders
EA	: Emotional Availability
ED	: Eating Disorder
ER	: Emotion Regulation
ERT	: Emotion Regulation Therapy
HPB	: Helicopter Parenting Behaviors
HPBQ	: The Helicopter Parenting Behaviors Questionnaire
LEAP	: The Lum Emotional Availability of Parents
NES	: Night Eating Syndrome
OCD	: Obsessive Compulsive Disorder
OSFED	: Other Specified Feeding or Eating Disorders
PD	: Purging Disorder
PTSD	: Posttraumatic Stress Disorder
S-BED	: Subthreshold Binge Eating Disorder

S-BN	: Subthreshold Bulimia Nervosa
SES	: Socioeconomic Status
SPSS	: Statistical Package for the Social Sciences
UFED	: Unspecified Feeding or Eating Disorder
USA	: United States of America
WHO	: World Health Organization



CHAPTER I

INTRODUCTION

The impact of parenting practices on children's psychological well-being and the long-term implications for their adult lives cannot be underestimated (Stewart-Brown et al., 2005; Repetti et al., 2002). Research has consistently shown that helicopter parenting, a prevalent parenting style in contemporary society throughout the world, has detrimental effects on children's development and mental health from the childhood to adulthood (Vigdal & Brønnick, 2022; Lin & Rahim, 2020). This is evident from studies drawing on Attachment theory underlying the influence of attachment quality and the attachment anxiety on the child (Bowlby, 1969) and Self-determination theory highlighting negative consequences of helicopter parenting on the child's autonomy, competence, and relatedness (Ryan & Deci, 2000). Furthermore, research have found a significant association between helicopter parenting and children's difficulties in regulating their emotions (Cui et al., 2019). These emotion regulation difficulties, in turn, have been linked to the severity of eating disorder symptoms. Additionally, parental emotional availability, characterized by emotional responsiveness and support, has been identified as a critical factor influencing a child's ability to regulate their emotions, with higher levels of parental emotional availability correlating with lower levels of emotion regulation difficulties.

Thus, this thesis examines the intricate relationship between perceived maternal and paternal helicopter parenting, perceived maternal and paternal emotional availability, emotion regulation difficulty and the severity of eating disorder symptoms in university students.

Following the introduction, the main concepts focused on this thesis will be elaborated in the light of the existing literature. Later, the method section will include the sample features, measures employed, procedure and conducted statistical analyses. After the method section, the results section will provide the findings of the statistical analyses. The concluding part of the study will center on the discussion of results, strengths and possible implications for clinical practice, drawbacks, and future research directions.

CHAPTER II

THE CONCEPTS

This chapter of the thesis will begin with the presentation of types, prevalence, etiology, effects, and theories of eating disorders. Subsequently, brief information about parenting styles will be given and the concept of helicopter parenting will be defined. In this part, helicopter parenting will be elaborated based on the attachment theory and self-determination theory. Moreover, the relationship between helicopter parenting and the severity of eating disorder symptoms will be covered. Later, parental emotional availability, which is another parental concept, and its relationship with helicopter parenting, emotion regulation difficulty and eating disorder symptoms will be covered, respectively. Afterwards, the concept of emotion regulation difficulty and its relationship with helicopter parenting and eating disorders will be given. Lastly, the possible relationship between helicopter parenting, parental emotional availability, emotion regulation difficulty and eating disorder symptoms will be presented within the scope of the relevant literature. At the end, the aims of the present study will be provided.

2.1. Eating Disorders

According to Fairburn and Walsh (2002), an eating disorder refers to a consistent pattern of irregular eating or weight-controlling behaviors that seriously impact an individual's physical and psychological wellness. It is essential that the disorder is not assigned to an identified health condition or the other psychological disorder.

2.1.a. Types of Eating Disorders

The DSM-5 (APA, 2013), which is The Diagnostic and Statistical Manual of Mental Disorders, establishes a cluster called Feeding and Eating Disorders, consisting of seven diagnostic categories: Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding or Eating Disorder, and Unspecified Feeding or Eating Disorder. Although these disorders share some psychological and behavioral features, they

exhibit diverse clinical courses, outcomes, and treatment needs. However, apart from Pica, they are categorized as mutually exclusive, allowing only one diagnosis during an episode.

In contrast, obesity is not categorized as a psychological condition in the DSM-5 because obesity, characterized by additional body fat resulting from a lasting imbalance between caloric intake and expenditure, develops due to a blend of genetic, physiological, behavioral, and environmental aspects, which differ among individuals (APA, 2013).

Recently, in 2022, the APA revised the DSM-5 and published DSM-5-TR to provide comprehensive updates, introduce new diagnostic entities, modify existing diagnostic criteria, and update terminology. For example, they included a sentence in the description of atypical anorexia nervosa, clarifying that individuals with this condition may experience many of the same physical complications as those with typical anorexia nervosa. This addition aimed to emphasize that the presence of physiological complications during presentation does not necessarily indicate a diagnosis of typical anorexia nervosa (APA, 2022).

In the following sections, we will provide a more in-depth exploration of the subcategories of eating disorders.

2.1.a.i. Anorexia Nervosa

According to the DSM-5 (APA, 2013), anorexia nervosa is diagnosed based on three key characteristics. The first characteristic is persistent calorie restriction, often through strict dieting. The second characteristic is a severe apprehension about weight gain or becoming overweight, which persists even as weight decreases. Individuals with anorexia nervosa often associate their self-esteem with their body shape and weight, viewing losing weight as an accomplishment and gaining weight as a deficit in self-control. The third characteristic is an impaired perception of personal weight or physical appearance. Individuals with anorexia nervosa perceive themselves as heavier than they actually are, and their body weights are lower than what is considered healthy for their specific characteristics such as age and physical health.

Other traits associated with anorexia nervosa include engaging in excessive physical activity to prevent weight gain, misuse of medications to control weight, compulsive weighing and measuring of body parts, and constant scrutiny of one's appearance in the mirror. Individuals with anorexia nervosa may also exhibit concerns

about eating in public, rigid thinking, a need for controlling the environment, limited emotional expression, and social difficulties.

Anorexia nervosa typically develops during adolescence or early adulthood, often triggered by stressful events such as leaving home for college (Jagielska & Kacperska, 2017). Determining normal weight can be challenging as it varies from person to person. Different thresholds have been established to identify insufficient weight. In body mass index (BMI), 18.5 kg/m² considered the lower boundary of the average weight for adults by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO). BMI values below 18.5 kg/m² are categorized as underweight (CDC, 2022). According to WHO (2006), BMI with and above 17.0 kg/m² indicates mild severity of weight loss, BMI between 16 and 16.99 kg/m² shows moderate severity of weight loss, and BMI between 15 and 15.99 kg/m² is the indication of severe weight loss, and BMI below 15 kg/m² refers to extreme level of severity and insufficient weight for adults. However, when assessing underweight individuals, factors such as body type, weight history, and physiological impairments should be considered (APA, 2013).

The DSM-5 identifies subtypes of anorexia nervosa. The Restricting Type (AN-R) involves weight reduction achieved by means of caloric restriction and intense workout, while lacking of repeated binge eating or purging behaviors. The Binge-eating/purging Type (AN-BP), on the other hand, includes episodes of binge eating or purging behavior. There can be crossovers between these subtypes, and individuals with the binge/purging type often exhibit higher impulsivity rates and a greater likelihood of substance abuse (APA, 2013; Moskowitz & Weiselberg, 2017).

To conclude, anorexia nervosa is characterized by persistent calorie restriction, a severe fear of weight gain, and a distorted perception of one's own weight or appearance. It typically develops during adolescence or early adulthood and can be triggered by stressful events. Different thresholds, such as BMI values, are used to identify insufficient weight. The DSM-5 recognizes two subtypes: Restricting Type, involving losing weight through dietary changes and physical activity, and Binge-eating/purging Type, with episodes of binge eating or purging behaviors.

2.1.a.ii. Bulimia Nervosa

Bulimia nervosa is identified by recurring instances of excessive eating, accompanied by inappropriate actions taken to avoid an increase in weight and a strong

focus on body image and weight. To receive a diagnosis, these episodes of overeating and behaviors aiming to compensate over-eating have to appear at least once per week and during more than three months (APA, 2013).

Binge eating episodes involve consuming more food in a specific timeframe than the majority of individuals would do in similar situations. It is accompanied by a sense of losing control, although under specific circumstances, it may be intentional. Negative emotions, such as stress, restrictive diets, negative thoughts about appearance, body image, and boredom, often trigger binge eating. The act of binge eating provides short-term relief but can lead to long-term negative self-evaluation and emotional distress. People with bulimia nervosa tend to hide their symptoms due to shame. Thus, binge eating often occurs secretly.

Inappropriate compensatory behaviors, known as purging, are a key component of bulimia nervosa. Vomiting is the most common method used to avoid weight gain. Individuals may induce vomiting by using their fingers or other objects to trigger the gag reflex. Some may even resort to ipecac syrup. Abuse of laxatives and diuretics, and other methods like overtraining or fasting are also employed to purge and prevent weight gain.

Period of adolescence or early adulthood is when bulimia nervosa typically starts. Individuals with bulimia nervosa can be of average weight or overweight (BMI ≥ 18.5 and < 30 in adults). They place a significant emphasis on appearance of their body and weight, similar to those with anorexia nervosa, experiencing body dissatisfaction, fear of weight gain, and an aspiration for weight loss (APA, 2013).

In summary, bulimia nervosa is marked by repeatedly bingeing and then engaging in compensatory behaviors intended to avoid weight gain. These behaviors include vomiting, excessive exercise, laxative use and fasting. The disorder typically begins during adolescence or early adulthood. People suffering from bulimia nervosa frequently experience a strong fixation on appearance of their body and weight.

2.1.a.iii. Binge-Eating Disorder

Binge eating disorder shares similarities with bulimia nervosa, such as a lack of control and significant distress related to binge eating. However, binge eating disorder is distinct from bulimia nervosa by the lack of compensating actions. To be diagnosed with binge eating disorder, repeated occurrences of binge eating episodes must happen at a minimum of once per week and for a duration of three months.

During a binge eating episode, certain criteria must be met, including eating faster than normal, feeling extremely overeat, consuming excessive amounts of food despite lacking hunger, eating in isolation due to shame, and experiencing feelings of disgust, depression, or guilt afterwards. At least three of these conditions must be present for a diagnosis (APA, 2013).

Binge eating disorder can affect individuals with obesity and overweight, but it differs from obesity in terms of the severity of psychological issues, concerns about weight and shape, and quality of life. It is important to emphasize that most individuals with obesity do not eat repetitively (Wonderlich et al., 2009).

Binge eating disorder is often seen to develop during the teenage years or early adulthood, although it may also manifest during later stages of life. Unlike bulimia nervosa, where dysfunctional dieting often precedes binge eating, in many cases of binge eating disorder, dieting follows the onset of binge eating (APA, 2013).

2.1.a.iv. Avoidant/Restrictive Food Intake Disorder

Unlike anorexia nervosa, which is defined with a distorted body image, Avoidant/Restrictive Food Intake Disorder (ARFID) is characterized by restricted food intake that leads to either macronutrient or micronutrient deficiency (Hay et al., 2017). The primary diagnostic characteristic of ARFID is avoiding or restricting food intake, resulting in significant undernutrition.

To diagnose ARFID, at least one of the essential components must be present, including notable weight loss, nutritional inadequacies, reliance on enteral nutrition or dietary supplements, and disturbances in functioning. Reliance on enteral nutrition or dietary supplements refers to needing additional nutrition to maintain sufficient intake.

Food avoidance or restriction in ARFID can be triggered by various factors such as scent, shape, or hypersensitivity to the taste of food. This can manifest as restrictive eating, selective eating, or food neophobia, where individuals are unable or unwilling to consume certain food brands. Avoiding foods or restricting intake can also be a learned response related to previous unpleasant experiences related to eating.

ARFID often develops during infancy or early childhood due to inadequate intake or indifference to food, which may persist into adulthood. Similarly, avoidance of food based on sensory qualities typically starts in the first ten years of life and may continue into adulthood.

To receive an ARFID diagnosis, the avoidance or restriction of food must not be explained by cultural norms, such as religious fasting or typical eating habits. Additionally, excessive worry about appearance or weight, as well as any concurrent medical conditions or mental illnesses, cannot fully account for the avoidance or restriction of food intake.

2.1.a.v. Pica

Pica is identified with the continual consumption of substances with no nutritional value for at least one month, severe enough to require attention. It includes various types, such as eating paper, soap, cloth, or hair. To receive a diagnosis of pica, the ingestion of these non-nutritional, non-food items should be developmentally inappropriate for the person's age and not a part of cultural or social normative practices (APA, 2013). For instance, swallowing the engagement ribbon to get a marriage proposal is one of the cultural beliefs in Türkiye (Nisan merasiminde neden kurdele yutulur?, 2022). Thus, it may not be considered as an indication of the Pica.

Pica can occur at any stage of life, but it is more commonly reported during childhood. The diagnosis is typically made for individuals who are at least 2 years old. Pregnant women may also experience pica when specific cravings manifest during pregnancy, but the diagnosis is only given if the consumption of non-nutritious, non-food items pose potential medical risks.

Intellectual disability and autism spectrum disorder are the two conditions that most frequently co-occur with pica. However, schizophrenia and obsessive-compulsive disorder can also be present, albeit less commonly. Excoriation (skin-picking) disorder and trichotillomania (compulsive hair-pulling) are other conditions that can coexist with pica, often involving the ingestion of the skin or hair in such cases (APA, 2013).

2.1.a.vi. Rumination Disorder

The key features of rumination disorder involve repeated regurgitation of ingested food, lasting for at least a month. The absence of visible nausea, involuntary vomiting, or disgust during the regurgitation process, and the willingness to re-swallow or re-chew the food before expelling it from the mouth are notable characteristics. Regular occurrence of this behavior, happening several times a week, typically on a daily basis, sets it apart. It is crucial to rule out any underlying

gastrointestinal or medical conditions, like diabetes, and ensure that it is not connected to the other eating disorders. Accurate diagnosis and differentiation from other disorders are vital for effective management and treatment. If rumination disorder coexists with another psychological condition, such as intellectual disability or a neurodevelopmental disorder, the symptoms must be sufficiently important to necessitate clinical attention and should be the major area of focus for treatment (APA, 2013).

Rumination disorder is relatively rare compared to other eating disorders in the world (Halland et al., 2018). While rumination can be observed at any age in individuals with developmental delays, it typically emerges between 3 and 12 months of age in children with normal development.

2.1.a.vii. Other Specified Feeding or Eating Disorders (OSFED)

According to research, other specified feeding or eating disorders (OSFED) is the most commonly reported category of eating disorders in studies with clinical or community samples (Smink et al., 2012). OSFED is used when symptomatic signs of an eating disorder are present, causing considerable discomfort or impairments across multiple domains of functioning, but the specific criteria for certain eating disorders are not fully met. It encompasses subcategories such as Atypical Anorexia Nervosa (A-AN), Subthreshold Bulimia Nervosa (S-BN), Subthreshold Binge Eating Disorder (S-BED), Purging Disorder (PD), and Night Eating Syndrome (NES).

In A-AN, individuals exhibit all the diagnostic criteria for anorexia nervosa except for one key difference: despite experiencing significant weight loss, their current weight remains within or above the acceptable range. This means that even though they may have lost a considerable amount of weight, their body weight is not below what is considered acceptable according to standard medical guidelines.

S-BN refers to cases where inappropriate compensatory behaviors occur less frequently or for a shorter period than necessary for a diagnosis of bulimia nervosa, but other criteria for the disorder are still met.

S-BED involves meeting all the requirements for binge-eating disorder, except that the binge eating episodes occur less frequently or for a shorter duration than the diagnostic threshold of once per week for three months.

PD is identified by continuous purging behaviors (e.g., laxative misuse, diuretic use) to alter weight or shape without engaging in binge eating.

NES refers to frequent occurrences of eating either right after waking from sleep or post dinner. The eating episodes are consciously remembered, and they cannot be attributed to changes in sleep-wake cycles or social norms. Significant distress and functional impairment are associated with nighttime eating, and it cannot be more suitably described by binge-eating disorder or other psychological problems or medication side effects.

Studies have demonstrated that OSFED has similar negative effects on the body and psychological well-being as more traditional eating disorder types like anorexia nervosa or bulimia nervosa (Thomas et al., 2009).

2.1.a.viii. Unspecified Feeding or Eating Disorder (UFED)

UFED is a diagnostic category used when the symptoms of a feeding and eating disorder result in substantial discomfort or impairment in important domains of functioning, but they do not fulfill the specific conditions for particular disorder within the feeding and eating disorders category. It is used when there is either inadequate information available to formulate a more precise diagnosis or when the clinician deliberately opts not to disclose the rationale for not meeting the criteria for a particular category. UFED serves as a way to acknowledge and address cases that do not fit neatly into existing diagnostic criteria but still require clinical attention (APA, 2013).

2.1.b. Incidence and Prevalence Rates of Eating Disorders

In recent years, there has been a surge in epidemiological studies focusing on eating disorders due to increased attention. However, these studies often failed to encompass all types of eating disorders. Also, there have been wide variations in the reported prevalence rates among the general population. According to a worldwide review, lifetime occurrence rate of AN, BN, and BED are 0.16 percent, 0.63 percent, and 1.53 percent, respectively. Western countries have indicated a lifetime occurrence rate of EDs at 1.89%, with rates in women reaching up to 2.58% (Qian et al., 2021). A report based on information from 15 countries indicated a lifetime prevalence of 1.0 percent for BN and 1.8 percent for BED, with average 12-month prevalence estimated at 0.4 percent for BN and 0.8 percent for BED. The onset of eating disorders tends to occur at a young age, with BN typically manifesting earlier (median age at onset: 21 years) compared to BED (median age at onset: 24 years) (Scott et al., 2018).

Additional studies have further contributed to our understanding of eating disorder prevalence. One study involving 24,124 participants from 14 countries found a global lifetime occurrence rate of 1% for BN, with rates varying between 0% and 2% in Romania and other countries (Kessler et al., 2013). Another study in the USA, taking as a reference point of DSM-5 criteria, reported lifetime occurrence rates of 0.8 percent for AN, 0.28 percent for BN, and 0.85 percent for BED (Udo & Grilo, 2018). In a study involving six European countries and a total of 21,425 participants, the lifetime occurrence estimates for AN, BN, and BED were found to be 0.48 percent, 0.51 percent, and 1.12 percent, respectively (Preti et al., 2009). Prevalence rates for AN fell between 0.2 and 0.5 percent in the European population, while rates for BN ranged from 0.1 to 0.9 percent (Wittchen et al., 2011). A study carried out in Saudi Arabia revealed a lifetime occurrence rate of 6.1% for one of the eating disorders, with 26% having BED, 28% having BN, and 6% having AN (AlHadi et al., 2022).

Specific studies focused on certain populations have also provided valuable insights. In a rural area of Türkiye, a study involving university students found the prevalence of eating disorders to be 2.12 percent, with BN accounting for 1.57 percent among females and BED identified in one out of three male subjects (0.31 percent) (Kugu et al., 2006). In another study involving 1584 college students it was discovered that 7.4 percent of female students and 3.6 percent of male students exceeded the clinical cut-off criteria for the Eating Disorders Examination Questionnaire (Ince, 2020).

While the evidence base for well-specified eating disorders such as AN, BN, and BED is relatively robust, the other types of eating disorders have a smaller evidence base. Studies have found that OSFED have a lifetime occurrence of 4.8 percent in adults and 4.6 percent in adolescents (Le Grange et al., 2012). The prevalence rate for ARFID in the general public remains unclear, with limited documentation available (Bryant-Waugh, 2019). A study in Australia reported a 3-month prevalence of ARFID at 0.3 percent (Hay et al., 2015). The prevalence of NES in adult men was revealed to be 0.7 percent (Fischer et al., 2012). Additionally, the lifetime occurrence of PD was predicted to be 2.1 percent, with a higher occurrence among women (Micali et al., 2017).

Gender divergences in eating disorders have been observed in various studies, with women having a higher likelihood of developing eating disorders (Hudson et al., 2007; Preti et al., 2009; Kessler et al., 2013; Nagl et al., 2016). However, one study based on

the Saudi National Mental Health Survey did not identify any gender-based differences (AlHadi et al., 2022). Occurrence rates of eating disorders exhibit significant variations, particularly in countries of low- and middle-income, which are likely due to differences in detection methods (Hay et al., 2023).

The age at death for individuals with different eating disorders varies, with AN-related deaths occurring at a younger age (25 to 34) compared to BN (35 to 44) and BED-related deaths. OSFED shows a similar age distribution to BN (Fichter & Quadflieg, 2016).

Several studies from Northern Europe were combined in a meta-analysis to examine the incidence of AN in mental health care. In Europe, the recorded incidence of AN increased until the 1970s and has remained stable since then (Smink et al., 2012). Conversely, the incidence of bulimia nervosa has shown a significant increase in the latter half of the 20th century (Hudson et al., 2007).

To conclude, in recent years, eating disorders have gained more attention, leading to an increase in epidemiological studies. However, there are variations in reported prevalence rates, and many studies do not include all types of eating disorders. In terms of gender divergences, women tend to experience eating disorders more, but there are some differences across countries. The age at death varies depending on the eating disorder, with AN associated with earlier mortality and BED with later mortality.

2.1.c. Etiology of Eating Disorders

Numerous studies have been carried out to investigate the predisposing conditions related to eating disorders. The emergence of an eating disorder is influenced by a diverse array of factors, encompassing genetic, biological, psychological, and environmental influences.

2.1.c.i. Genetics

Multiple research studies have contributed significant insights into the intricate genetic factors that contribute to the manifestation of eating disorders. The pathogenesis of these complex conditions, encompassing a range of disorders. Among the various eating disorders, research investigating the neural mechanisms underlying AN has revealed that the brain's natural systems responsible for processing feelings of pleasure and reward, which are associated with serotonin and dopamine, are not functioning optimally in individuals with AN. Consequently, they may turn to

restrictive eating patterns as a way to alleviate their anxiety and achieve a sense of control (Kaye et al., 2013). Moreover, BN and obesity have been particularly explored in relation to genetic influences. Emerging evidence suggests that six specific genetic polymorphisms may be intricately linked to the development of BN and obesity. These polymorphisms are associated with crucial neuroendocrine receptors, such as dopamine, serotonin, and cannabinoid receptors, along with an estrogen receptor and the FTO gene. These genetic variations have been hypothesized to contribute to the dysregulation of neural pathways and processes involved in appetite regulation, impulse control, and mood regulation, ultimately impacting an individual's vulnerability to BN and obesity (Nicoletti et al., 2019). Furthermore, the scope of genetic research in the context of eating disorders goes beyond polymorphisms, as investigations have also explored the role of mutations and variations in genes. Such genetic alterations have been shown to potentially predispose individuals to developing eating disorders by influencing critical biological pathways and neurotransmitter systems that govern eating behaviors (Qasim et al., 2019; Sabbagh et al., 2016). These collective findings emphasize the intricate interplay between genetic factors and the diverse spectrum of eating disorders, offering valuable insights into potential risk factors and avenues for future research and targeted treatments.

2.1.c.ii. Biological Factors

Research on biological risk factors has been primarily centered on the dysregulation of the gut microbiome, which has been implicated in the psychopathology of eating disorders (EDs). In individuals with EDs, disruptions in the gut microbiome and its metabolites have been associated with disordered eating patterns (Glenny et al., 2017). Besides, research has explored the role of certain proteins produced by bacteria in the gut, which might mimic or influence human hormones involved in appetite regulation. For instance, increased levels of CIPB protein have been found to be associated with elevated peptide YY levels in individuals with AN and AN-R (Eddy et al., 2015). According to Breton et al. (2016), gastrointestinal infections and inflammation leading to increased levels of *E. coli* bacteria in the gastrointestinal tract have been linked to higher peptide YY levels and a potential elevated risk of developing EDs. Additionally, autoimmune and autoinflammatory diseases have shown a notable association with a higher risk of

developing EDs. Evidence suggests that underlying immune dysregulation might be a contributing factor in this relationship (Zerwas et al., 2017; Barakat et al., 2023).

To conclude, research on biological risk factors in EDs focuses on the dysregulation of the gut microbiome and the presence of autoimmune and autoinflammatory diseases. Disruptions in the gut microbiome and elevated peptide YY levels are linked to disordered eating patterns in EDs. Autoimmune and autoinflammatory diseases increase the risk of developing EDs. Further studies are necessary to enlighten these relationships and explore interventions.

2.1.c.iii. Psychological Factors

Psychological risk factors play a significant role in predisposing individuals to develop EDs. Family dynamics, personality features, adverse life events, traumatic experiences, and comorbidity with other disorders have been identified as important factors in the development of EDs.

Family relationships and the perception of parent-child interactions have been examined in relation to EDs. Individuals with AN and BN have reported experiencing less warmth and emotional attachment from their parents compared to their siblings without EDs (Amianto et al., 2011). Furthermore, individuals lacking secure attachment to their families and unmet emotional needs are at a higher risk of developing EDs, while those who have healthy and valued relationships with their families exhibit a lower frequency of EDs (Alantar & Maner, 2008). This highlights the importance of secure emotional bonds in reducing the risk of EDs. Negative weight-related attitudes and high standards from parents, particularly mothers, are associated with an increased risk of developing EDs (Allen et al., 2014). Parental dominance and unhappy childhood experiences are also considered risk factors for the development of EDs (Micali et al., 2017). In addition, overprotection in families, emotional unresponsiveness, and intergenerational interference may contribute to the development of EDs (Mayhew et al., 2018).

Moreover, stressful life experiences, childhood adversities and history of abuse, familial problems have a substantial influence in the development of binge/purge type EDs such as AN-BP, BN, BED, and PD (Larsen et al., 2017; Solmi et al., 2021). Specifically, emotional abuse has been identified as a risk factor for all core eating disorder psychopathology (Monteleone et al., 2019). These findings highlight the

importance of considering the impact of adverse experiences and trauma during childhood in understanding the etiology of eating disorders.

In terms of gender-specificity, Micali et al. (2017) found that females who perceive less maternal warmth are more likely found to develop binge/purge type EDs. In addition, low parental warmth appears to increase the risk of EDs in females but not in males (Krug et al., 2016), indicating potential perceptual differences of the child regarding to parental attitudes.

Personality factors also contribute to the onset of EDs. Low self-esteem and distorted body perception are considered risk factors (Erol et al., 2000; Uskun & Şabaplı, 2013). Being anxious, perfectionistic, and having obsessive-compulsive traits are commonly related to a higher risk of developing EDs (Farstad et al., 2016). Specifically, perfectionism plays a significant role in the onset and continuation of EDs, including AN, BN, and OSFED (Holland et al., 2013). Obsessiveness is closely related to AN, particularly the drive for thinness (Levinson et al., 2019). Moreover, it has been shown that impulsivity and compulsivity, when interacted, can influence ED symptoms and disease severity (Farstadt et al., 2016). Farstadt et al. (2016) also reported that individuals with binge/purge eating disorders (e.g., BN and AN-BP) exhibit higher levels of anxiety, depression, avoidance, emotion dysregulation and paranoia. According to Prefit et al. (2019), the failure to be aware of emotions and difficulty in emotional control are related to eating disorder symptoms are not specific to a particular diagnosis. This suggests that lack of emotional awareness and emotional dysregulation can be common factors across various types of eating disorders.

Comorbidity with other disorders also increases the risk of EDs. Childhood anxiety disorders, such as obsessive-compulsive disorder (OCD), often occurs earlier in life than the emergence of an ED (Micali et al., 2011). Besides, EDs and borderline personality disorder (BPD) frequently co-occur. In addition, the most frequently encountered psychological comorbidities in individuals with EDs are mood and anxiety disorders (Navarro-Haro et al., 2015; Godart et al., 2015; Rojo-Moreno et al., 2015). Additionally, autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and posttraumatic stress disorder (PTSD) are psychological conditions that appear to increase the risk of EDs (Grilo et al., 2012; Huke et al., 2013; Nazar et al., 2016).

Overall, these psychological risk factors interact with each other and with biological, environmental and cultural factors to contribute to the development of EDs (Barakat et al., 2023).

2.1.c.iv. Environmental and Cultural Factors

Environmental and cultural factors have a significant impact on the development of eating disorders. These factors can include socio-economic status (SES), body image ideals propagated by media and culture, and the influence of cultural values regarding body image.

In terms of SES, research has shown that high parental educational background can predict an increased risk of EDs (Bould et al., 2016). However, disordered eating behaviors seem to occur at similar rates across different employment statuses and income levels (Mulders-Jones et al., 2017). This suggests that while certain aspects of SES might be associated with ED risk, other factors may be more influential in the development of these disorders.

Preoccupation, dissatisfaction, and negative perceptions about their own physical appearance and body shape contributes to the development of EDs. Dissatisfaction with one's body and internalizing the thinness ideal are indicators of ED onset (Evans et al., 2017). Both males and females are influenced by the ideal thin body, and exposure to these ideals through media has been linked to a higher risk of developing EDs (Hausenblas et al., 2013).

It is essential to recognize that cultural values regarding body image can significantly impact the prevalence of EDs in different parts of the world. In Western cultures, thinness has traditionally been related to beauty and attractiveness, while in Eastern cultures, being plump has historically been associated with fertility and family care (Nasser, 1997). However, as cultures become more interconnected and influenced by global media, young people in Eastern societies have started to adopt Western values regarding body appearance (Eapen et al., 2006). Consequently, both Eastern and Western societies have experienced similar changes in the prevalence rates of eating disorders (Makino et al., 2004).

In summary, the risk factors for eating disorders are multifaceted, encompassing genetic, biological, psychological, environmental and cultural influences. Genetic factors, particularly family history, play an important role in the emergence of eating disorders. Biological factors, such as gut microbiome

dysregulation and autoimmune diseases, have also been related to a elevated risk of developing eating disorders. Psychological risk factors include family dynamics, adverse life events, personality traits, and comorbid disorders. Finally, environmental and cultural factors, such as body image ideals propagated by media and changing values in different societies, also contribute to the emergence of eating disorders. The examination of risk factors for eating disorders provides valuable insights into the complex interplay of genetic, biological, psychological, environmental and cultural influences. Understanding these factors sets the stage for comprehending the profound and wide-ranging effects that eating disorders can have on individuals' physical, emotional and social well-being.

2.1.d. Effects of Eating Disorders

Eating disorders have extensive impacts on the body, affecting various systems and leading to a range of medical complications. These complications include cardiovascular, neurological, gastrointestinal, endocrine, and dermatologic issues.

In anorexia nervosa (AN), the most severe complications arise from low body weight and malnutrition. Physical signs such as pale or yellow skin, cold and blue extremities, and changes in vital signs such as low blood pressure, heart rate and body temperature are common. Hair loss on the scalp is prevalent, and some individuals develop lanugo (fine, downy hair) on their arms and trunks. Gastrointestinal discomfort such as bloating, and constipation can occur. In addition, AN is often accompanied by electrolyte abnormalities, below average red blood cells, white blood cells and platelets, cardiac arrhythmias and bone marrow suppression (Westmoreland et al., 2016). Amenorrhea (absence of menstrual periods) and abnormal vital signs are common physiological indications of anorexia nervosa. While most physiological disturbances linked to malnutrition can be reversed through nutritional intake, the other complications (e.g., decrease in density of bone mineral) may not always be curable.

Individuals with severe cases of anorexia nervosa may also exhibit depressive symptoms, including feelings of sadness, social isolation, irritability, sleep problems, and a decreased interest in sexual activities. These symptoms may be a physiological manifestation of semi-starvation, as they can also be observed in individuals who are severely undernourished but do not have anorexia nervosa. In some cases, the depressive symptoms may be severe enough to consider major depressive disorder (APA, 2013).

In bulimia nervosa (BN), self-induced vomiting can lead to hypokalemia (low potassium levels), minor electrocardiogram (ECG) changes known as ST changes, and metabolic acidosis or alkalosis. Chronic regurgitation of gastric contents can result in oral issues such as perimylolysis (erosion of tooth enamel), swelling of the parotid glands, and damage to the soft palate. Dehydration and water loss can cause dry skin, while edema, stomach and intestinal problems, and irregular menstrual cycles may also occur (Kontić et al., 2012; Westmoreland et al., 2016). Substance use is notably common among individuals diagnosed with bulimia nervosa, with a lifetime prevalence of at least 30%. A particularly prevalent pattern involves the use of stimulant substances, which often starts to regulate appetite and prevent weight gain. (APA, 2013).

Mortality rates among individuals with EDs are significantly high. AN has the highest mortality rates among all psychological disorders, with approximately 5% of AN patients dying from the disorder each year (Arcelus et al., 2011; APA, 2013). In a longitudinal study, mortality among AN patients was found to be five times higher compared to the general population, with a rate of 5.35 percent. The leading causes of death in AN are suicide and medical complications directly associated with the disorder. Cachexia, organ failure, and circulatory collapse were the main causes of death in individuals with AN, with suicides accounting for a significant portion of non-organic causes of death (Fichter & Quadflieg, 2016). In a comprehensive analysis of twelve studies on suicide deaths in AN patients, it was found that one in five individuals with AN who died had died by suicide, resulting in a suicide mortality rate of 1.39 percent (Arcelus et al., 2011). Other eating disorders, such as BN, BED, and OSFEDs, also had elevated standardized mortality rates (Fichter & Quadflieg, 2016).

In addition to the physical complications and mortality rates, eating disorders have a significant negative impact on individuals' quality of life, particularly in terms of mental health. Studies have shown that individuals with eating disorders experience low mental health-related quality of life, and this is particularly pronounced in individuals with BED and ARFID (Hay et al., 2017; Jenkins et al., 2011).

To sum up, eating disorders have wide-ranging effects on the body, including cardiovascular, neurological, gastrointestinal, endocrine, and dermatologic complications. Besides, eating disorders have high mortality rates, with suicide and medical complications being common causes of death. Furthermore, individuals with

eating disorders experience a significant negative impact on their quality of life, particularly in terms of mental health.

It is essential to recognize that certain groups, such as university students, are at a significantly higher risk of developing eating disorders. The prevalence of eating disorders among university students has been a growing concern, making it crucial to understand the unique risk factors and challenges this population faces in order to implement targeted prevention and intervention strategies. Thus, the next section will cover the university students which consist of the sample of the present study in terms of eating disorders.

2.1.e. University Students: A Significant Risk Group for Developing Eating Disorders

It is well-established that the onset of eating disorders generally take place during the progression to adulthood, with the average age of emergence for anorexia nervosa and bulimia nervosa falling 15-19 age bracket, and for binge eating disorder, it is shortly after, around 23 to 24 years (Hudson et al., 2007; Kessler et al., 2013). This age range coincides with the period when many individuals are transitioning from high school to university, making it a critical time for the development of eating disorders. A study found that the highest annual mean prevalence of eating disorders was estimated to be around the age of 21, which aligns with the university age (Ward et al., 2019).

Eating disorders are thought to affect 2-4 percent of young adults (Hudson, et al., 2007), and subthreshold eating problems are reported by a larger number of university students. For female university students, estimates of the prevalence of eating disorders over a 12-month period range from 17 percent to 90 percent (Berg et al., 2009), and for male university students from 8 percent to 30 percent (Dakanalis et al., 2016). A screening study conducted on multiple university campuses in the USA found that approximately 60% of participants were at high risk of developing an eating disorder or exhibited symptoms at a clinical or subclinical level (Fitzsimmons-Craft et al., 2019). Similarly, a study conducted in Istanbul with 1080 participants found that the variance rates explained for the risk of developing eating disorders were 31% among female university students, 42.6% among male university students, and 33.2% for the entire group (Kermen et al., 2019). This suggests that both female and male university students are susceptible to the risk of developing eating disorders.

The transition to adulthood and the challenges associated with entering university and assuming adult responsibilities can contribute to the increased risk of developing clinically significant eating disorders. This period often involves leaving the family home, exploring one's identity, managing demanding academic work, and facing interpersonal pressures. These factors, combined with the physical changes of young adulthood, can create a vulnerable environment that raises the risk of eating disorders (Harrer et al., 2020; Potterton et al., 2020). This phenomenon is not limited to Western countries but has also been observed in Eastern countries (Sahlan et al., 2020). Eating disorders are recognized as a significant and common problem among university students in Türkiye as well (Sanlier et al., 2008). They found that eating disorders are more commonly observed in females than males, with a higher risk seen in 17.2% of underweight individuals and 21.2% of those who are overweight. Therefore, the current study takes the university students as participants into the consideration.

In the next section, the attachment theory will be presented as the theoretical model for understanding eating disorders in this study.

2.1.f. Attachment Theory

Various theoretical frameworks have been suggested to elucidate the underlying causes and persistent elements contributing to eating disorders. One of the most influential theories is Attachment Theory, as originally proposed by John Bowlby in 1969. It highlights that newborn infants are biologically predisposed to seek proximity to a primary attachment figure, typically a parent with the behaviors of crying and holding tightly, which are crucial and adaptive for survival of an infant because proximity seeking behaviors enable the caregiver to serve as a safe haven in times of threat. Additionally, as the infant grows into a young child, this attachment system continues to be valuable, as the child learns to use the caregiver as a secure base for exploration. While venturing out to explore the environment, the child intermittently seeks reassurance through eye contact, affirming the caregiver's comforting presence. This dynamic of seeking comfort and reassurance from the caregiver, while simultaneously exploring the world fosters a sense of security, facilitating healthy emotional and cognitive development in the child (Bowlby, 1969). These initial interactions with primary caregivers form the foundation for the development of cognitive templates of attachment, which act as mental frameworks

for future relationships (Siegel, 1999). These models are encoded in the implicit memory system and shape individuals' styles of interaction, emotion regulation, and coping strategies (Bowlby, 1988).

Later, in order to understand the dynamics of attachment and the quality of the bond between an infant and their primary caregiver, Ainsworth and colleagues have utilized a method known as the Strange Situation procedure. This procedure involves subjecting infants to a series of separations and reunions with their primary caregiver in a controlled laboratory setting. By observing the infant's reactions during these separations and reunions, researchers can gain insights into the infant's attachment style and the nature of their relationship with the caregiver. Individual variations in infant reactions during the Strange Situation procedure led to the identification of three primary attachment classifications: secure attachment, anxious/avoidant attachment, and anxious/ambivalent attachment (Ainsworth, et al., 1978; Ainsworth & Wittig, 1969). A fourth attachment style, known as disorganized attachment, was later pronounced by Main and Solomon (1986). Anxious/avoidant attachment, anxious/ambivalent attachment and disorganized attachment were known as insecure attachment styles. According to Bowlby (1977), attachment bonds initially form in infancy, but he emphasized that the capacity to form attachment bonds exists throughout the lifespan. While the early years of life are crucial for the establishment of primary attachment relationships, Bowlby recognized that attachment dynamics continue to play a role in relationships and emotional well-being across different stages of development.

Researchers have extensively examined the relationship between attachment styles and eating disorders. Research findings from various studies support the notion that secure attachment is more prevalent among individuals without eating disorders, while anxious and avoidant attachment styles are more commonly observed among individuals with eating disorders (Evans & Wertheim, 1998; Friedberg & Lyddon, 1996; Latzer et al., 2002).

A review study examined the subgroups of eating disorders with regard to attachment styles. The findings of the review study revealed that different subgroups of eating disorders were associated with distinct attachment styles. For example, individuals with bulimia nervosa tended to exhibit higher rates of attachment preoccupation. On the other hand, individuals with the restricting subtype of anorexia nervosa showed a relatively higher prevalence of attachment dismissal. It is

noteworthy that in other diagnostic subgroups, the distribution of attachment classifications was more evenly spread among the various insecure attachment styles. This implies that individuals with different types of eating disorders may display diverse patterns of attachment insecurity, and there is no specific attachment style that consistently dominates across all diagnostic subgroups (Zachrisson & Skårderud, 2010).

Attachment theory could shed light on potential factors contributing to the emergence and continuation of eating disorders in adulthood (Tasca & Balfour, 2014). It serves as a useful framework for comprehending the indirect effects in the connection between parenting styles and eating pathology in young adults. This pathway indirectly links parenting styles to the emotional competency and self-competence of the children, which are interconnected with the attachment theory (Hampshire et al., 2022; Laible, 2007). According to a study by Tasca et al. (2009), attachment styles impact emotion regulation strategies, which subsequently influence the appearance of eating disorders symptoms. The researchers propose that the emotions of individuals with eating disorders, particularly those with anxious attachment style, may be overactive, which can manifest in purging or binge eating disorders. This heightened emotional state may serve as a coping mechanism for dealing with unbearable emotions. By engaging in behaviors such as bingeing or purging, individuals may temporarily alleviate their emotional distress or seek a sense of control over their feelings. On the other hand, eating disorder patients with attachment avoidance tend to disconnect from their emotional experiences. They may engage in extreme dietary restriction as a means to suppress or avoid emotional arousal. By restricting their food intake, they create a physical and emotional numbing effect, which allows them to maintain a sense of control and distance from their emotions. In both cases, individuals with different attachment styles utilize maladaptive coping strategies related to their emotional experiences.

In summary, Attachment Theory provides a comprehensive framework for understanding the emergence and continuation of eating disorders. It emphasizes the importance of the bond between the child and the parent and how attachment styles influence emotion regulation strategies, which, in turn, can contribute to the emergence of eating disorders. In the next step, parenting styles will be focused because parenting styles influence attachment formed between the child and the parent, which, in turn, can impact the risk of developing eating disorders.

2.2. Parenting Styles

Parents play a leading role in every stage of child development. Many studies suggest that parental behavior and attitudes primarily influence children, and its lifelong developmental effects cannot be ruled out (Lerner, 1982). According to Darling and Steinberg (1993), parenting styles include a set of attitudes, such as love, care, concern, towards the child, and they form an emotional climate between the parent and the child. It is suggested that parenting styles should be broken down into their component parts to comprehend the processes influencing the child development. With this notion, many classifications have been made regarding parenting types.

At the beginning, researchers based their study of parenting styles on a dimensional approach. They identified dimensions of detachment/involvement, emotional warmth/hostility, autonomy/control and warmth and indulgentness (Baldwin, 1948; Sears, et al., 1957; Schaefer, 1959). According to this approach, it was found that parental availability, responsiveness, support for individuality, and appropriate control were almost always related with the child's successful developmental outcomes (Baldwin, 1948; Sears et al., 1957). However, Baumrind (1966) realized the shortcomings of the dimensional approach in recognizing the interaction effects of different parenting dimensions. Thus, she proposed a typological approach to study parenting styles. Baumrind (1971, 1978) determined parenting styles according to the level of responsiveness (warmth) and demandingness (control) of the parents to their children. Supporting the child's goals and desires, expressing love and pleasure, and responding to a child's requests for attention in a way that is appropriate and timely are operationalized as signs of parental warmth (Belsky et al., 2007). Restrictions, control, and rules toward the children are characteristics of the demandingness. There are three distinct parenting styles that result from the intersection of these two dimensions named as authoritarian, permissive, and authoritative.

The first one is the authoritarian parenting defined by highly restrictive and demanding, but low responsive parental behaviors. Parents make all decisions on the behalf the child without considering the child's needs. They want the children to act within the framework of certain family rules. When they do not follow the rules, they are punished.

The second one is the permissive parenting style including totally flexible, compassionate, and accepting behaviors allowing the child to self-regulate and not be constrained. That is, parents who were low in demands and high in responsiveness exhibited a permissive/indulgent parenting style. These two categories reflect the extremes of the behavioral continuum.

The third category forming a balance between the extremes is the authoritative parenting style. They keep an eye on their child's behavior, while giving autonomy to the child, demand appropriate behavior, and praise their successes. Verbal feedback from these parents is friendly and encouraging (Baumrind, 1991).

Later, Maccoby and Martin (1992) added another type of parenting to Baumrind's styles which is uninvolved/neglectful style. Uninvolved/neglectful parents are those who are less responsive and less demanding. They don't watch over their kids or participate in their interests or extracurricular activities. They basically ignore or reject their children and fail to fulfill necessary parenting duties.

The influence of parenting styles on a child's whole development and well-being has been the subject of extensive research. The findings reveal that the most positive child outcomes can be achieved when adopting the authoritative parenting (Baumrind, 1991). In this condition, the children develop an internal locus of control and a positive self-image (McClun & Merrell, 1998). Another study conducted by Lamborn et al. (1991) demonstrated that on tests of psychosocial competence and academic performance, adolescents of authoritative parents consistently received higher scores. Additionally, they frequently received lower ratings for both on externalizing and internalizing behaviors. On the other hand, adolescents raised by authoritarian parents showed success in the school and were not engaged in problematic behaviors, but generally had poor social skills, low self-esteem and tended to have higher depression rates compared to their peers raised by authoritative parents. Also, uninvolved/neglectful parenting style typically resulted in the least positive outcomes. Adolescents growing up with these kinds of parents performed the worst in terms of social skills, psychosocial adjustment, and academic achievement. Adolescents of authoritarian and indulgent parents fell in the middle of the other two groups. Adolescents growing up with authoritarian parents reported fewer problem behaviors (misconduct, drug use, etc.), exhibited less internalized distress and a more positive attitude toward school compared to adolescents growing up with indulgent parents. These findings tended to hold true for various demographic groups.

To conclude, parenting styles tend to remain consistent throughout the developmental stages of the child (Zhang et al., 2017), and they have been linked to various psychopathological consequences in child, such as eating disorders in both adolescence (Erriu et al., 2020) and adulthood (Grogan et al., 2020).

In the subsequent section, we will explore the concept of helicopter parenting in more detail, examining its impact on children.

2.2.a. Helicopter Parenting

Apart from the four commonly known parenting styles, there are also different parenting styles. Helicopter parenting, which is one of the parenting styles, differs from others in terms of showing excessive care and control that is not consistent with the age of the child. (LeMoyne & Buchanan, 2011). Helicopter parenting is first mentioned in the book of Dr. Haim Ginott named *Parents & Teenagers* after adolescents said that the parents fly over them like a helicopter (Bradley-Geis & Olson-Buchanan, 2014). In 1990, the concept of “helicopter parent” was used by Foster Cline and Jim Fay. Helicopter parenting refers to over parenting because they constantly try to achieve excessive involvement and excessive control in the lives of their children (LeMoyne & Buchanan, 2011; Padilla-Walker & Nelson, 2012; Schiffrin et al., 2014).

Research suggests that helicopter parenting to some extent is similar to parental control, particularly psychological and behavioral control (PadillaWalker & Nelson, 2012). However, there are also differences between helicopter parenting and these forms of control. Psychological control involves manipulating children's thoughts and emotions, which is not characteristic of helicopter parenting (Reed et al., 2016). Additionally, unlike behaviorally controlling parents, helicopter parents both limit their children's autonomy and provide support and warmth. Therefore, helicopter parenting is considered a distinct factor separate from behavioral and psychological control (Padilla-Walker & Nelson, 2012).

Children can be exposed to helicopter parenting from a young age (Hong et al., 2015) during and after university years (Bernstein & Triger, 2010). It involves behaviors such as constant supervision, directing activities, and hindering independent play during the toddler stage (Bradley-Geist & Olson-Buchanan, 2014). In school-age children, it includes efforts to find reliable teachers, determining friends and activities, and providing excessive help with schoolwork (Bristow, 2014). Common behaviors during this stage also include contacting teachers for low grades, implementing strict

study schedules, and enrolling the child in private lessons (Kouros et al., 2017). Helicopter parenting's influence extends beyond childhood, impacting decisions related to higher education, marriage, living arrangements, and relationships in later years (Fingerman et al., 2012; Yoo et al., 2016).

Developmental needs of the child changes as the child grows. Thus, parents should adjust their behaviors and level of involvement in the children to align with the children's evolving developmental needs. However, helicopter parents may not adequately respond to the age-relevant needs of their children, particularly at the times of university education (Padilla-Walker & Nelson, 2012). As a result, it is crucial to conduct an accurate assessment of how young adults perceive helicopter parenting and to understand the functional or dysfunctional aspects of this parenting style during this specific developmental period, as aimed in this study. Such an investigation can provide significant insights into the influence of helicopter parenting on young adults and shed light on its implications for their well-being and overall development.

Helicopter parenting shares some characteristics with the authoritarian parenting style, which is typically linked to less favorable child outcomes. Numerous studies have reported a significantly higher prevalence of anxiety and depression in children with helicopter parents compared to their peers (Garner, 2017). Insufficient development of life skills and low self-efficacy have been identified as common outcomes, as expressed by a lack of belief in one's own abilities (van Ingen et al., 2015; Reed et al., 2016; Kouros et al., 2017). Other frequently observed consequences include social phobia, obsession, and panic disorders (Murray et al., 2009; Reed et al., 2016; Garner, 2017). Research has shown that helicopter parenting, characterized by excessive control and intrusion, can disrupt the development of secure attachments between parents and children. This constant monitoring and over involvement can hinder the child's ability to form autonomous and independent relationships. In some cases, children with helicopter parents may experience an excessive development of entitlement, leading to problems extending into narcissistic personality traits (Eberly-Lewis et al., 2018).

Both helicopter and authoritarian parenting display a failure to give a child some degree of autonomy. According to Peterson and Hann (1999), strict parental control typically has a negative impact on children because it is related to satisfy the needs of the parent instead of those of the child. They give their children the impression that they are helpless to deal with their own problems, and they require constant

safeguarding from external threats. Unlike authoritarian parenting style, helicopter parenting includes responsiveness toward the child. Helicopter parenting also differs from authoritative parenting style in that it leaves no room for the child's autonomy. Permissive parenting also shares some characteristics with helicopter parenting such as a strong level of responsiveness to the child's needs. However, low directiveness of permissive parents makes it the antithesis of helicopter parenting. For those reasons, it has been shown to be a different parenting style that is not very beneficial to the child, although it is performed for good intentions (Padilla-Walker & Nelson, 2012).

According to a comprehensive study conducted in the USA, involving over 3,600 participants from various regions, helicopter parenting focused on meeting the needs of the child has become pervasive and is considered the norm (Ishizuka, 2019). This phenomenon is not limited to specific social groups but has been observed across diverse backgrounds. In fact, research suggests that this type of parenting is prevalent both in the USA and many other nations around the world (Anderson, 2019).

In the context of Türkiye, a cultural norm that aligns with helicopter parenting tendencies has been identified. Research by Kağıtçıbaşı (1996) highlights that a controlling parenting style can be observed as a common practice in Turkish families when raising children. Moreover, recent studies focusing specifically on the parenting practices in Türkiye have shed light on the extent of helicopter parenting in the country. A study by Yılmaz (2020) revealed that approximately one-third of mothers and one-seventh of fathers in Türkiye exhibit helicopter parenting behaviors. Moreover, the study indicates that the perceived level of helicopter parenting among fathers has experienced a rapid increase. In terms of the consequences of helicopter parenting, a study conducted with Turkish university students indicates that psychological symptoms, inflated sense of self and impulsivity are linked positively to perceptions of helicopter parenting by the mother (Set, 2020). Furthermore, it has been observed that children of helicopter parents feel more loneliness (Taymaz, 2019), have higher depression scores (Okray, 2016), and exhibit high levels of dependent personality traits (Erkan, 2019) compared to children raised with other parenting styles. These findings demonstrate that helicopter parenting is not only a global phenomenon but also a growing trend with negative effects on the child within the Turkish society.

Taken together, the evidence suggests that the prevalence of helicopter parenting is widespread and transcends cultural and geographical boundaries. The normalization of intensive and controlling parenting styles, as seen in various studies

conducted in the USA, Türkiye, and other nations, underscores the need to critically examine the impact of such parenting practices on child development and well-being. Understanding the global scope of this parenting style allows for a broader perspective on its consequences and the importance of promoting healthier and more balanced approaches to parenting.

2.2.a.i. Theoretical Models for Helicopter Parenting

Research has shown that helicopter parenting, characterized by excessive control and intrusion, can disrupt the development of secure attachments between parents and children as attachment theory highlights the importance of secure emotional bonds and responsive caregiving in promoting healthy child development (Bowlby, 1969). This constant monitoring and over-involvement can hinder the child's ability to form autonomous and independent relationships. Consequently, the child may become overly reliant on their parent's constant guidance and approval, leading to an insecure attachment style characterized by anxiety and dependency (Vigdal & Brønnick, 2022). Furthermore, attachment theory emphasizes the importance of responsive and attuned caregiving, where parents consistently meet the emotional and physical needs of their children (Bowlby, 1969). Helicopter parents, while well-intentioned, often hover over their children's every move, shield children from adversity, can impede the child's development of autonomy and self-regulation (Reed et al., 2016). This overprotection can hinder their ability to navigate challenges, make decisions, and develop resilience. However, attachment theory suggests that children need opportunities to explore their environment, take risks, and develop problem-solving skills (Bowlby, 1969). Consequently, the principles of attachment theory encourage secure attachments and the development of independence, while helicopter parenting tends to inhibit these processes by being overly controlling and limiting the child's autonomy. Striking a balance between providing support and allowing freedom is crucial for healthy child development.

The detrimental effects of helicopter parenting on child development are further supported by the principles of Self-Determination Theory, as introduced by Ryan and Deci (2000). This theory highlights three fundamental needs that are inherent in every individual and crucial in promoting physical and psychological health when met. Conversely, when these needs are unmet, they can contribute to psychopathology.

The first need described by Self-Determination Theory is autonomy. This refers to an individual's perception of being able to make decisions and choices independently. When children are constantly subjected to helicopter parenting, their sense of autonomy is undermined as their parents make decisions for them, leaving little room for them to develop and exercise their own judgment. The second need is competence, which involves having confidence in one's own skills and abilities. Helicopter parenting can hinder the child's development of competence by constantly intervening, taking over tasks, and not allowing the child to take risks or face challenges on their own. This can result in a lack of belief in their own capabilities and a reduced sense of competence. The third need is relatedness, which encompasses the desire to establish and maintain meaningful and caring relationships. Helicopter parenting may compromise the child's sense of relatedness as it often involves intrusive behavior and an excessive focus on control rather than fostering genuine emotional connections. This can lead to strained parent-child relationships and a diminished sense of authentic and supportive connections. According to Self-Determination Theory, for an individual to thrive and flourish, all three needs of autonomy, competence, and relatedness need to be adequately met. However, helicopter parenting disrupts the fulfillment of all these fundamental needs, potentially hindering the child's overall well-being and development (Vigdal & Brønnick, 2022). By excessively controlling and interfering in their children's lives, helicopter parents undermine their sense of autonomy, competence, and relatedness. This not only damages the parent-child relationship but also hampers the child's ability to develop a strong sense of self, confidence in their abilities, and healthy social connections.

2.2.a.ii. Helicopter Parenting and Eating Disorders

Parents' influence on children's development and mental health into adulthood has consistently been emphasized by researchers (Belsky, 1984). Even though helicopter parenting looks beneficial for the child, most studies found that both maternal and paternal helicopter parenting can negatively affect children's mental health (Vigdal & Brønnick, 2022; Lin & Rahim, 2020). Research indicates that helicopter parenting may cause anxiety (Segrin et al., 2013) and depression (Schiffrein et al., 2014). Additionally, poorer academic success (Luebbe et al., 2018) and decreased well-being (Schiffrein et al., 2014), self-control (Perry et al., 2018), and self-efficacy (Reed et al., 2016) have all been associated with helicopter parenting.

Nevertheless, studies examining the relationship between eating disorders and helicopter parenting are quite scarce, and existing studies have revealed contradictory results. On the one hand, in a thesis study on helicopter parenting, it was found that there is a negative relationship between perceived helicopter parenting and disordered eating (Fitzgerald, 2015). However, working with a small sample (24 male and 67 female participants) casts doubt on the results. On the other hand, in a qualitative study, participants stated eating problems such as obesity and binge eating due to the stress caused by helicopter parenting (Kwon et al., 2017). In addition, while studies reveal a negative relationship between parental care and problematic eating behaviors, overprotective parenting, especially overprotective motherhood, has a positive relationship with problematic eating behaviors (Turner et al., 2005). Studies also indicated associations between both paternal and maternal overprotection and food preoccupation related to disordered eating (McEwen & Flouri, 2009; Meesters et al., 2007). Additionally, adolescents who have controlling parents displayed various disordered eating symptoms, including internalized preoccupation with muscle and externalized intensive weight control behaviors (Meesters et al., 2007; Berge et al., 2014). For such reasons, there is a need to study further the relationship between helicopter parenting including high-level care and control and the risk of developing eating disorder symptoms, and it is important to study this relationship in order to see and prevent the impact of helicopter parenting on university students in Türkiye.

In the subsequent section, we will delve into another important concept related to parenting, namely parental emotional availability.

2.3. Parental Emotional Availability

The construct of Parental Emotional Availability was defined in 1991, initially for research purposes, to reflect standards for parent-child interaction (Biringen, 2000). As explained by Biringen and Easterbrooks (2012), emotional availability (EA) is a complex and interactive construct that is influenced by the relationship dynamics between caregiver and the child. It is based on principles from attachment theory and systemic perspectives.

The EA Scales, developed by Biringen and Easterbrooks (2012), serve as a measurement tool for assessing emotional availability and examining the quality of interactions between caregivers and children. These scales consist of four key dimensions of caregiver attitude (nonintrusiveness, sensitivity, nonhostility and

structuring) and two features of child reactions (involvement and responsiveness with the parent). Each of these dimensions is evaluated within the context of the caregiver-child dyad. While most studies using the EA Scales have primarily focused on parent-child relationships during infancy and childhood, the concept of EA remains applicable to understanding dyadic relationships throughout the entire lifespan.

Main characteristics of parental emotional availability includes the degree of being responsive, sensitive and emotionally involved with the child (Biringen & Robinson, 1991). Emotionally available parents accept and support a variety of child behaviors regardless of being negative or positive (Easterbrooks & Biringen, 2000). Being emotionally unavailable means that the parent can be physically present, but emotionally absent (Aviezera et al., 2003). Studies found that the child experiences greater distress in the case of an emotionally unavailable mother in contrast to mother's physical absence (Field, 1994). Thus, parental emotional unavailability creates a risk for the development of psychopathology in children, while parental emotional availability is a protective factor during the time of adolescence (Vassallo et al., 2012).

Both fathers and mothers form attachments with the child in a similar way. Therefore, it is important to study emotional availability of both parents (Lum & Phares, 2005). However, perception of parental emotional availability differs between genders of parents. For instance, adolescent girls report mothers as more emotionally available than fathers (Penelo et al., 2012). Therefore, it could be important to consider gender of parents while evaluating perceived parental emotional availability.

2.3.a. Helicopter Parenting and Parental Emotional Availability

The concepts of helicopter parenting and parental emotional availability may exhibit certain similarities in their definitions. For instance, helicopter parenting involves being responsive to the child's needs. However, this excessive level of responsiveness can hinder the child's development of skills to manage their emotions and behavior (Padilla-Walker & Nelson, 2012). On the other hand, parental emotional availability emphasizes both the adult's ability to be responsive and attuned to the child's emotional cues and needs as well as their positive and nurturing emotional presence (Saunders et al., 2015). Even though there is a shared factor among helicopter parenting and parental emotional availability, these two concepts can be considered separately.

In literature, there has been only one study that investigated the association between helicopter parenting and parental emotional availability. This study found no significant correlation between helicopter parenting and the emotional availability of parents (Erkan, 2019). However, this study considered the combined scores from both mothers and fathers without separately examining the specific contributions of each parent. Since the perception of parenting differs between mothers and fathers, this study aims to observe the child's perception of each parent. By examining the specific contributions of each parent separately, a more comprehensive understanding of the relationship between helicopter parenting and parental emotional availability can be gained.

2.3.b. Parental Emotional Availability and Emotion Regulation Difficulty

Research consistently highlights the importance of parental emotional availability for the emotional development of children. Several studies have demonstrated positive associations between parental emotional availability and various aspects of emotional competence in children.

For example, a study by Karaoğlu (2018) focused on adult daughters and found a positive correlation between fathers' emotional availability and the emotional development of their daughters. Similarly, Volling et al. (2002) conducted an observational study that examined mother-child and father-child interactions over a one-year period. They found that the emotional presence of parents was associated with the emotional competence of children.

Furthermore, research with adolescent mothers has emphasized the significance of consistent parental emotional availability in predicting children's emotion regulation ability. Toraif (2018) discovered that an optimal level of emotional availability, neither too little nor too much, was associated with better emotion regulation in children. Thus, it was suggested that when children perceive their parents as emotionally unavailable, they may struggle to develop emotional competence and encounter difficulties in regulating their emotions.

In relation to emotion regulation difficulties, previous studies have indicated a relationship with parental emotional availability. Ülkümen (2021) conducted a study with university students and found that both maternal and paternal emotional availability negatively predicted the child's emotion regulation difficulties.

Specifically, paternal emotional availability accounted for 6.7% of the variance, while maternal emotional availability accounted for 7% of the variance.

These findings collectively demonstrate that parental emotional availability plays a crucial role in the emotional development and emotion regulation abilities of children. Children who perceive their parents as emotionally available are more likely to develop emotional competence and effectively regulate their emotions. However, it is essential to maintain an optimal level of emotional availability, as both excessive and insufficient emotional availability can have adverse effects on a child's emotional well-being.

In the subsequent section, the existing literature regarding the association between parental emotional availability and eating disorders will be discussed.

2.3.c. Parental Emotional Availability and Eating Disorders

Studies looking at the relationship between parental emotional availability and eating disorders indicates conflicting results. Some of them claims that EA can be a protective factor in the onset of ED. For instance, a positive association between mother-daughter/father-daughter dyads and daughters' healthy eating habits has been reported by Byely et al. (2012). Gökçe (2013) asserts that having emotionally available parents serves as a buffer against adversities in a child's life, which potentially reducing the risk of developing disordered eating behaviors. Similarly, Roy (2021) discovered a negative correlation between the emotional availability of both mothers and fathers and the current occurrence of disordered eating among university students.

However, the others have failed to establish a link between parental emotional availability and eating disorders. Cordero and Israel (2009) did not find an association between emotional availability and dysfunctional eating habits. Additionally, in a study, there were no observed differences between the subgroups of anorexia nervosa in terms of emotional availability, and no significant association was found between emotional availability and the severity of eating disorder (Criscuolo et al., 2023).

These inconsistent findings highlight the complexity of the relationship between parental emotional availability and eating disorders. It is important to note that various factors, such as cultural context, individual differences, and the specific dynamics within parent-child relationships, may contribute to these contradictory results. Moreover, the assessment and measurement of parental emotional availability and eating disorders can vary across studies, potentially influencing the outcomes.

Given the significance of parental emotional availability in parenting research, further investigation is warranted to reach more robust conclusions regarding its relationship with eating disorder symptoms. Therefore, the present study will also consider potential effect of parental emotion availability for both mother and father on the child.

2.4. Emotion Regulation Difficulty

In addition to understanding the relationship between parental emotional availability and eating disorders, it is essential to consider the broader context of emotion regulation difficulty. Emotion regulation encompasses the skill of effectively managing and adjusting emotions to cope with diverse situations and achieve personal goals (Gratz & Roemer, 2004).

Various models have been proposed to understand the process of emotion regulation (ER). One such model is the Process Model by Gross (1998). This model defines ER as a set of strategies individuals employ to modify their emotional experiences, behaviors, and physiological responses associated with emotions. In this model, it is suggested that five points in the emotion-generating process allow for the regulation of emotions. These include choosing the situation, changing the situation, focusing attention (i.e., selecting the conditions of a situation to attend), shifting cognitions (i.e., the alteration of one's evaluation of a situation), and modulating responses (i.e., the immediate alteration of emotion-related reactions). Also, Gross suggests that regulatory processes are either antecedent-focused (i.e., those used at the beginning of emotion formation) or response-focused (i.e., those that control all reactions that characterize feelings, sensations, and perceptions). Researchers have applied this model to explore the connection between specific ER strategies and symptoms of clinical disorders. For instance, Aldao and colleagues investigated six key ER strategies, categorized as adaptive or maladaptive, based on their associations with the development and persistence of clinical disorders. While some ER techniques, like rumination, avoidance, and suppression, have been demonstrated to be maladaptive responses, while others, such as, acceptance, reappraisal, and problem-solving appear to be adaptive across a range of contexts. Therefore, some people use adaptive techniques more often, while others use maladaptive techniques more. This may differ in terms of situation and time. In fact, a person can have a specific as well as a general difficulty in emotion regulation (Aldao et al., 2010; Aldao & Nolen-Hoeksema, 2010; 2012a; 2012b).

Further, Eisenberg et al. (2013) defined emotion regulation as the techniques used to control and alter whether, how, and when a person experiences emotions, the physiological conditions associated with emotions, and the behavioral patterns in which emotions are expressed. It is important to note that emotion regulation is distinct from emotional control, as it does not aim to immediately decrease negative affect but rather involves modifying the experience of emotions (Cole et al., 1994).

Apart from Process Model of Gross, Gratz and Roemer (2004) proposed a comprehensive model of emotion regulation that encompasses four key dimensions. Firstly, it involves the recognition, comprehension, and acceptance of one's emotional experiences. Secondly, it entails the capacity to participate in purposeful actions and restrain impulsivity at the times of experiencing negative emotions. Thirdly, it encompasses the utilization of relevant strategies for a situation to modulate the strength and length of emotional reactions. Finally, it emphasizes the readiness to embrace negative emotions as an essential aspect of engaging in meaningful pursuits and experiences in life. Within this framework, it is suggested that if individuals exhibit deficiencies in any of these four domains, they are likely to experience difficulties in regulating their emotions, known as emotion dysregulation or emotion regulation difficulty. In the present study, the model of Gratz and Roemer will be utilized. Next, the relationship between helicopter parenting and emotion regulation will be considered in the scope of existing literature.

2.4.a. Helicopter Parenting and Emotion Regulation Difficulty

In 1993, Linehan proposed a biosocial model for emotion regulation difficulty experienced by the patients with borderline personality disorder and from that time it is used for the explanation of emotion regulation difficulty in many other disorders (Monell et al., 2015). According to this model, the development of emotion regulation difficulty can be understood as a dynamic interplay between personal vulnerabilities and temperament, such as heightened emotional sensitivity and reactivity, and the presence of invalidating responses of the society and the family (Linehan, 1993; Fruzzetti et al., 2005). Within this framework, parenting can be considered among one of the factors predisposing individuals to develop emotion regulation difficulties. Attachment theory provides further support for this idea by highlighting that attachment anxiety, characterized by a heightened fear of rejection and abandonment, is associated with maladaptive emotional regulation strategies (Bowlby, 1969).

Individuals high in attachment anxiety tend to overreact to negative emotions, directing excessive attention towards threats. They may also perceive themselves as helpless and inadequate in effectively managing their emotions, leading to a tendency to excessively rely on others for emotion regulation (Mikulincer & Shaver, 2005). This perspective also aligns with the Self-Determination Theory, which identifies three necessary needs for successful child development: autonomy, competence, and relatedness (Ryan & Deci, 2000). However, the concept of helicopter parenting, characterized by excessive control, overprotection, and intrusion into a child's life, violates all these fundamental needs because it restricts a child's autonomy, fails to provide opportunities for the child to develop their own competence in challenging situations, and fosters excessive dependence on parents and other individuals, which hindering their ability to form autonomous and healthy relationships.

Studies have provided support for the relationship between helicopter parenting and difficulties in emotion regulation (Love et al., 2022; Cui et al., 2019). For instance, recent research conducted with Turkish emerging adults demonstrated a positive association between helicopter parenting and challenges in emotion regulation (Guclu et al., 2022). These findings further highlight the adverse impact of helicopter parenting on the development of emotion regulation skills of the child.

2.4.b. Emotion Regulation Difficulty and Eating Disorders

Emotion dysregulation or emotion regulation difficulty is involved in the etiology and continuation of different types of psychological disorders. Thus, it has been suggested that it serves as a transdiagnostic factor underlying a number of psychological disorders (Gross et al., 2011; Gross, 2013).

An extending body of research has showed an association between emotion dysregulation and eating disorders. It is reported that EDs are significantly influenced by problems in distinguishing, defining and controlling emotions (Leehr et al., 2015; Lavender et al., 2015). For instance, results of a study indicate that individuals with AN exhibit higher emotion dysregulation compared to the individuals in the control group, and emotion dysregulation does not differ between AN-R and AN-BP (Svaldi et al., 2012; Brockmeyer et al., 2014). Besides, Svaldi et al. (2012) have shown that individuals with eating disorders are less able to use adaptive strategies to regulate their emotions than individuals in healthy control groups. These individuals also report lower emotional awareness, more emotional suppression and avoidance, issues with

managing their emotions, and lower emotional awareness. Specifically, individuals with AN have deficits especially in adaptive emotion regulation strategies. These deficits may manifest difficulty in changing their perspective on situations, finding opportunities for personal growth, being aware of their emotions without judgment, and fostering positive thinking. Likewise, greater emotion dysregulation is stated by individuals with BN than healthy controls. In a meta-analysis, anorexia nervosa and bulimia nervosa also showed strong associations with rumination, avoiding emotions, and suppression (Prefit et al., 2019). In fact, Racine and Wildes (2013) demonstrated that more severe ED symptomatology is directly correlated with ED patients who exhibit higher levels of emotion dysregulation.

The findings propose that emotion regulation difficulty is not specific to a particular diagnostic category but rather manifests as a common feature in individuals with EDs. Overall, the evidence consistently supports the notion that EDs are linked to both a general difficulty in emotion regulation and deficits in specific adaptive emotion regulation skills. These insights highlight the importance of understanding and addressing emotion regulation difficulty in the assessment and treatment of individuals with eating disorders.

2.5. Helicopter Parenting, Parental Emotional Availability, Emotion Regulation Difficulty and Eating Disorder Symptoms

While there may be a direct link between helicopter parenting and the psychopathology of eating disorder symptoms, different mechanisms behind this relationship can also exist. One of these mechanisms could be an individual's difficulty in emotion regulation. Emotion regulation encompasses the various mechanisms and methods that individuals employ to perceive, understand, experience, express, and manage their emotions effectively (Gross, 1998). They may not always fully develop or acquired in a constructive and beneficial manner. Thus, difficulty in emotion regulation emerges (Gratz & Roemer, 2004).

Research indicates that as the perception of helicopter parenting increases, children of such parents may experience greater difficulties in emotion regulation (Cui et al., 2019). These difficulties in emotion regulation have also been linked to various psychological problems, including eating disorders (Monell et al., 2018). In accordance with these research findings, it is plausible that young adults who have

helicopter parents may be at risk of developing eating disorder symptoms due to difficulties in regulating their emotions.

Additionally, parental emotional availability, which refers to the level of emotional involvement, responsiveness, and sensitivity of parents towards their children, plays a crucial role in the development of an individual's emotion regulation abilities. Studies have demonstrated that as parental emotional availability increases, the difficulty in emotion regulation tends to decrease (Kelek, 2020). Therefore, both parental emotional availability and emotion regulation difficulties may serve as mediators in the relationship between helicopter parenting and the development of eating disorder symptoms in university students.

By considering the interplay between helicopter parenting, emotion regulation difficulties, and parental emotional availability, we can gain a deeper understanding of the potential pathways through which eating disorders may emerge in individuals with helicopter parents.

2.6. The Present Study

Although the helicopter parenting performed widely in the world and eating disorders are a widespread psychological disorder among adolescents and adults, the literature on helicopter parenting focuses more on depression and anxiety disorders.

However, there are studies related to parental control and overprotection which are the dimensions of helicopter parenting. They have consistently demonstrated a connection between parental overprotection, controlling parenting styles, and symptoms of disordered eating in both paternal and maternal parenting (McEwen & Flouri, 2009; Meesters et al., 2007). These parenting behaviors have been reported to be related to specific disordered eating symptoms, such as food preoccupation, muscle preoccupation, and extreme weight control behaviors (Meesters et al., 2007; Berge et al., 2014). Moreover, paternal psychological control and excessive protection have been related to various markers of disordered eating patterns among young individuals (McEwen & Flouri, 2009; Hautala et al., 2011).

Similar to the research exploring related topics such as disordered eating and overprotective parenting, there may exist both a direct and an indirect relationship between helicopter parenting and eating disorders. In addition to direct link, studies suggest a pathway indirectly links adverse parenting styles to the eating disorders (Hampshire et al., 2022). It is possible for individuals with helicopter parents to

develop eating disorder symptoms as a result of difficulties in regulating their emotions according to the previous research (Cui et al., 2019; Monell et al., 2018). Ülkümen (2021) demonstrated that both maternal and paternal emotional availability were negatively associated with the child's emotion regulation difficulties. In line with this, considering the impact of parenting factors such as parenting style and parental emotional availability on the development of emotion regulation difficulties, a potential simple or serial mediation between helicopter parenting and eating disorder symptoms severity could be considered. Despite these predictions, studies examining the relationship between helicopter parenting and eating disorder symptoms and its underlying mechanisms are scarce. Besides, there is no existing study that has specifically examined the mediating role of paternal emotional availability and emotion regulation difficulty in the relationship between helicopter parenting and the severity of eating disorder symptoms. While there is single research exploring the association between helicopter parenting and parental emotional availability, it has considered the combined scores from both mother and father forms, without separately examining the specific contributions of each parent (Erkan, 2019). Thus, further investigation is needed to explore the underlying mechanisms of the link between helicopter parenting and eating disorder symptoms to prevent eating disorders in university students. Thus, the specific mediator roles of parental emotional availability and emotion regulation difficulty in the relationship between helicopter parenting and eating disorder symptoms will be investigated in this study.

Moreover, studies in the literature propose that children may perceive similar parenting behaviors differently between mothers and fathers, and that traditional family roles and cultural norms play a role in this (Sümer & Güngör, 1999). For example, a study involving Turkish university students revealed that psychological symptoms, an inflated sense of self, and impulsivity were associated with helicopter parenting perceived from mothers, while there was no such correlation with perceived helicopter parenting from fathers (Set, 2020). Therefore, this study aimed to examine both perceived maternal and paternal helicopter parenting, as well as perceived maternal and paternal emotional availability, in order to explore potential gender-based differences among parents.

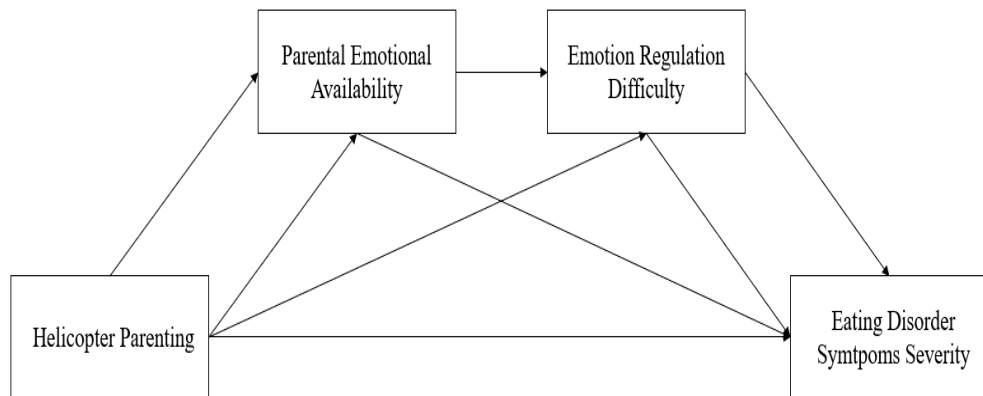
In the light of the reviewed literature, the present study aims to investigate the association between perceived parental helicopter parenting, perceived parental

emotional availability, difficulty in emotion regulation, and symptoms of eating disorders. In that sense, the hypotheses of the present study are specified in the below.

- (1) Helicopter parenting will be related to the severity of eating disorder symptoms.
 - a. Maternal helicopter parenting will be related to the severity of eating disorder symptoms.
 - b. Paternal helicopter parenting will be related to the severity of eating disorder symptoms.
- (2) Parental emotional availability will be related to the severity of eating disorder symptoms.
 - a. Maternal emotional availability will be related to the severity of eating disorder symptoms.
 - b. Paternal emotional availability will be related to the severity of eating disorder symptoms.
- (3) The difficulty in emotion regulation will be related to the severity of eating disorder symptoms.
- (4) Parental emotional availability will be related to the difficulty in emotion regulation.
 - a. Maternal emotional availability will be related to the difficulty in emotion regulation.
 - b. Paternal emotional availability will be related to the difficulty in emotion regulation.
- (5) The relationship between helicopter parenting and the severity of eating disorder symptoms will be mediated by parental emotional availability and the difficulty in emotion regulation.
 - a. The relationship between maternal helicopter parenting and the severity of eating disorder symptoms will be mediated by the difficulty in emotion regulation and maternal emotional availability.
 - b. The relationship between paternal helicopter parenting and the severity of eating disorder symptoms will be mediated by the difficulty in emotion regulation and paternal emotional availability.

The model of this study can be found in Figure 2.1.

Figure 2. 1. Model to Be Tested





CHAPTER III

METHOD

In this part, the sample characteristics, data collection tools, procedure and data analysis are presented, respectively.

3.1. Participants

In this study, the sample population consisted of 303 university students from Türkiye, with an inclusion criterion requiring both parents to be alive. This criterion was chosen to avoid potentially triggering negative emotions in participants who had lost one or both parents and to minimize memory errors that may occur when recalling parenting styles of deceased parents.

The sample included 80 male (26.4%) and 223 female (73.6%) participants. The participants' age varied from 17 to 30, with a mean of 21.73 and a standard deviation of 2.71. Regarding educational status, 249 (82.2%) were undergraduate students, 48 (15.8%) were graduate students, and the remaining were doctorate students (2%). The participants' body mass indices (BMI) ranged from 15.01 to 31.62 with a mean of 22.19, which corresponds to normal BMI. As for residency, 231 participants spent most of their lives in a metropolis (76.2%), 55 (18.2%) in a city, 8 (2.6%) in a town, and 9 (3%) in a village. 230 participants (75.9%) stated that they did not have any psychiatric/psychological disorders, while 73 participants (24.1%) indicated that they did. 14 of them (19%) indicated experiencing eating disorders, while 33 participants (45.2%) mentioned having anxiety disorders. Others specified the presence of OCD, depression, bipolar disorders, and ADHD. Furthermore, 20 participants (27.4%) indicated having multiple diagnoses.

In addition, it comes to family-related information. When the education levels of the participants' mothers were examined, it was found that 128 (42.2%) were university graduates or higher, 17 (5.6%) were graduated from vocational school, 74 (24.4%) were graduated from high school, 24 (7.9%) were graduated from middle school, 56 (18.5%) were graduated from elementary school, 2 (0.7%) were literate, and 2 (0.7%) were illiterate. For fathers, 165 (54.5%) were university graduates or higher, 27 (8.9%) were graduated from vocational school, 51 (16.8%) were graduated

from high school, 22 (7.3%) were graduated from middle school, 35 (11.6%) were graduated from elementary school, 3 (1%) were literate, and none of them were illiterate. In comparison to the general population in Türkiye, the educational levels of both mothers and fathers were found to be relatively high in this study. Out of the participants, 260 (85.8%) had parents that are married and together, 31 (10.2%) had divorced parents, 11 (3.6%) had parents who were legally married but living separately, and 1 (0.3%) had parents who were divorced but living in the same house. When asked with whom they currently live, 181 (59.7%) of the participants stated that they live with their family, 70 (23.6%) with their roommate from a dorm, 21 (6.9%) with a housemate, 10 (3.3%) with their partner, and 21 (6.9%) reported living alone. Moreover, 36 of the participants (11.9%) were the only child, the majority (45.2%) had two siblings, 88 (29%) had three siblings, 32 (10.6%) had four siblings, 5 (1.7%) had five siblings, 3 (1%) had six siblings, and 2 (0.7%) had seven siblings. Of these, 142 (46.9%) are firstborn, 110 (36.3%) are second-born, 40 (13.2%) are third-born, 6 (2%) are fourth-born, 3 (1%) are fifth-born, and the rest are sixth and seventh-born.

Finally, on the income level ladder ranging from 1 to 10, one participant (0.3%) placed themselves and their family on the first rung, 5 participants (1.7%) on the second rung, 10 participants (3.3%) on the third rung, 29 participants (9.6%) on the fourth rung, 40 participants (13.2%) on the fifth rung, 73 participants (24.1%) on the sixth rung, 94 participants (31%) on the seventh rung, 42 participants (13.9%) on the eighth rung, 6 participants (2%) on the ninth rung, and 3 participants (1%) on the tenth rung. Overall, average SES on the sample was 6 on an income ladder, which refers to slightly average to high SES (see Table 3.1.).

Variables	<i>n</i>	%
Gender		
Women	223	73.6%
Men	80	26.4%
Educational Status		
Undergraduate student	249	82.2%
Graduate student	48	15.8%

	Doctorate student	6	2.0%
Residency			
	Village	9	3.0%
	Town	8	2.6%
	City	55	18.2%
	Metropolis	231	76.2%

Presence of Psychological Disorders

No	230	75.9%
Yes	73	24.1%

Education Level of Mother

Illiterate	2	0.7%
Literate	2	0.7%
Elementary school graduate	56	18.5%
Middle school graduate	24	7.9%
High school graduate	74	24.4%
Vocational school graduate	17	5.6%
University graduate or higher	128	42.2%

Education Level of Father

Illiterate	0	0.0%
Literate	3	1.0%
Elementary school graduate	35	11.6%
Middle school graduate	22	7.3%
High school graduate	51	16.8%
Vocational school graduate	27	8.9%

University graduate or higher	165	54.5%
Marital Status of Parents		
Married and together	260	85.8%
Divorced	31	10.2%
Legally married but living separately	11	3.6%
Divorced but living in the same house	1	0.3%
Living Status		
Family	181	59.7%
Housemate	21	6.9%
Dormmate	70	23.1%
Partner	10	3.3%
Alone	21	6.9%

Note. N = 303. The participants had an average age of 22 years old ($SD = 3$) with an average Body Mass Index (BMI) of 22.19 ($SD = 3.03$). The mean number of siblings was 2.5 ($SD = 1$), and the average birth order was 1.8 ($SD = 0.9$). The average socioeconomic status (SES) of the sample was 6 on an income ladder ($SD = 2$).

Table 3.1. Sociodemographic Characteristics of Participants

3.2. Measures

In the present study, a demographic information form developed by the researcher, The Helicopter Parenting Behaviors Questionnaire (HPBQ), The Lum Emotional Availability of Parents (LEAP), The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16), The Eating Disorder Examination Questionnaire (EDE-Q) were used (see Appendix section).

3.2.a. The Demographic Information Form

It is a semi-structured form developed by the researcher to record the participant's sociodemographic information such as age, gender, educational status,

presence of psychological disorders, body mass index (BMI) and familial information (e.g., education level of parents, number of siblings, child order of the participant, currently living together or separately from the family, and socioeconomic level of the family) (see Appendix A).

3.2.b. The Helicopter Parenting Behaviors Questionnaire (HPBQ)

Schifffrin et al. (2014) developed a scale to assess university students' perceptions of their mothers' helicopter parenting and autonomy supportive behaviors. The scale comprises two subscales: Helicopter Parenting Behaviors (HPB), encompassing nine originally worded items such as "My mother closely monitors my dietary choices," and Autonomy Supportive Behaviors (ASB), consisting of six items such as "My mother encourages me to independently select my own courses." The 15-item scale uses a Likert-type response format ranging from 1 (Strongly disagree) to 6 (Strongly agree), and it demonstrated satisfactory internal consistencies with a coefficient of .77 for HPB and .71 for ASB.

Flouri and Buchanan (2003) found evidence indicating that paternal engagement played a significant role in promoting the overall welfare of children, surpassing and having a greater impact than maternal involvement. Since the original scale was worded just for the mother, to create the Father Form, Komurcu-Akik and Alsancak-Akbulut (2021) crafted and tailored the wording of the items specifically designed to assess fathers' involvement and participation. Moreover, they adapted the original scale into Turkish, separately for mothers and fathers. Internal consistency coefficients for the mother form yielded .78 for HPB and .80 for ASB, while for the father form, internal consistency coefficients were .80 for HPB and .84 for ASB. In the present study, the Cronbach's alpha coefficient for the mother form was .82 for both HPB and ASB, indicating good reliability. For fathers, the scale exhibited a reliability of .85 for HPB and .87 for ASB (refer to Appendix B and C for further details).

3.2.c. The Lum Emotional Availability of Parents (LEAP)

Lum and Phares (2005) developed a 6-point Likert-type scale to assess parental emotional availability. The scale measures individuals' perceptions of their parents' emotional availability and is scored using a range from 1 (never) to 6 (always). Higher scores on the scale indicate a higher perception of parental emotional availability. The

scale consists of 15 items that evaluate parental behaviors, such as "remembers things that are important to me." Participants assess their mothers and fathers separately. In a non-clinical sample, the scale exhibited a unidimensional structure. Additionally, it demonstrated strong internal consistency, yielding a Cronbach's alpha coefficient of .96 for the mother form and .97 for the father form. In a clinical sample, the internal consistency coefficients were .92 for the mother form and .93 for the father form. Test-retest reliability was found to be .92 for the mother form and .85 for the father form (Lum & Phares, 2005).

The scale was later adapted into Turkish by Gokce in 2013. The Turkish version exhibited high internal consistency, with Cronbach's alpha coefficients of .95 for the mother form and .97 for the father form. Item-test correlations ranged from .65 to .83 for the mother form and from .76 to .86 for the father form (Gokce, 2013). In the current study, the Cronbach's alpha coefficient for both the mother and father forms was .98 (see Appendix D for detailed information).

3.2.d. The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16)

Gratz and Roemer (2004) developed a 36-item scale to measure emotion regulation difficulty, which was shortened to 16 items in a version created by Bjureberg et al. (2016). This short form uses a 5-point Likert response format to measure five sub-dimensions of emotion regulation difficulties, including Clarity, Goals, Strategies, Nonacceptance, and Impulse. All of these dimensions relate to difficulties in regulating emotions.

Yiğit and Güzey-Yiğit (2017) conducted a validity and reliability study of the Turkish version of the short scale in a sample of university students. The internal reliability of the scale was .92 for the entire scale and varied from .78 and .87 for the sub-dimensions. In the present study, the Cronbach's alpha for the scale .92 (see Appendix E).

3.2.e. The Eating Disorder Examination Questionnaire (EDE-Q)

The Eating Disorder Examination Questionnaire, which was developed by Fairburn and Beglin (1994), is a 28-item scale designed to measure and diagnose eating disorders. The scale includes five subscales: Restriction (R), Binge Eating (BE), concerns about body shape (SC), concerns about eating (EC), and concerns about weight (WC), which reflect the severity of eating disorder psychopathology. The

subscale scores, except for the binge eating subscale, range from 0 (never in the last 28 days) to 6 (every day in the last 28 days), with higher scores indicating a greater presence of pathology. The total score is obtained by adding the scores of the 4 subscales (excluding binge eating) and dividing by 4. To receive a subscale score, the scores of the subscale questions are summed up and divided by the number of questions in the subscale.

The Turkish version of the scale was validated and found to be reliable by Yucel et al. (2011) with adolescents, with an internal consistency coefficient between .70 and .86 for the subscales and .93 for the whole scale. Baktiroglu et al. (2019) also found the scale to be reliable in adults, with an internal consistency coefficient of .92. In the present study, the Cronbach's alpha coefficient for the scale was .92 (see Appendix F).

3.3. Procedure

To conduct the study, ethical approval was taken from the Human Research Evaluation Board of the TOBB Economics and Technology University (see Appendix G). The online survey software Google Forms was utilized for the data collection. The survey was announced via posts shared on the social media and e-mails sent to the university students from e-mail box of the Psychology Application and Research Center of the TOBB ETU. At the start of the online survey, participants were given a written informed consent form (see Appendix H). After participants agreed to participate in the study and gave their informed consent, the demographic information form, The Helicopter Parenting Behaviors Questionnaire (HPBQ), The Lum Emotional Availability of Parents (LEAP), The Difficulties in Emotion Regulation Scale-Brief Form (DERS-16), The Eating Disorder Examination Questionnaire (EDE-Q) were completed, respectively. The questionnaires were finished in about 15 minutes. Participants filled the online questionnaire between October 2022 and February 2023 through social media announcements on posts. The adequacy of the sample size was decided with using statistical power analysis by G*Power 3.1 (Faul et al., 2009). For two models of mediation analyses with nine predictors for each, medium effect size (.15), a moderate level of significance ($\alpha = .05$), and a power of .80, the least necessary sample size for the present study was determined as 150.

3.4. Statistical Analyses

The data analysis for this study involved using version 24 of the Statistical Package of Social Sciences (SPSS) for Windows. For the mediation analyses, the PROCESS macro for IBM SPSS developed by Hayes (2018) was employed. A total of 370 participants were reached within the scope of this study. In the initial stage, 29 individuals who did not meet the inclusion criteria of the study (non-students, those with deceased parents, and those who did not approve to informed consent) were excluded. Subsequently, 2 individuals who did not specify their gender were also excluded from the study due to their potentially creating an outlier effect. Finally, although they met the inclusion criteria, 11 individuals who were not of the appropriate age for the nature of the study (for example, a 42-year-old undergraduate student) were not included in the study.

Besides, the data underwent tests for normality, data entry accuracy, and assumptions of univariate and multivariate analysis. Univariate analysis was conducted by converting the dependent variable (Eating Disorder Symptoms Severity) into a standardized score, and 3 participants whose scores fell outside the range of -3 to +3 were excluded from the study. Following that, multivariate outlier analysis was performed using the Mahalanobis distance test for both mother and father models ($X^2 = 12.592$, $p < .05$). It revealed 22 multivariate outliers that were removed from the data. As a result, the analyses were conducted with a total of 303 participants. Then, the internal reliability of the measures was evaluated using Cronbach's alpha coefficients.

Furthermore, multi-categorical variables were transformed into simpler categories. For instance, the educational status of participants was grouped as undergraduates and postgraduates. For residency, it was turned into two categories (which are rural and urban) when village, town and city were grouped together. Education level of mothers and fathers were coded into three categories according to Turkish education system which are primary education (including illiterate, literate, elementary school graduates and middle school graduates), secondary education (including high school graduates) and higher education (including vocational school graduates and university graduates or higher). In terms of parental status, physical closeness of parents was considered. Categories of divorced and legally married but living separately families were merged, and the other two categories were also combined. Finally, three categories were created for living status of participants such

as family, the others and alone. T-tests, ANOVA and the Kruskal-Wallis tests were conducted accordingly on categorical sociodemographic variables (e.g., gender) to examine potential control variables. Kruskal-Wallis tests were conducted in variables where the categories do not have an equal number of participants, and a category contains less than 30 participants such as marital status of parents and residency of participants. For the continuous variables (e.g., age), the correlations were examined.

Subsequently, descriptive statistics and bivariate correlations were computed for all variables. Before conducting the mediation analysis, the data was checked for the assumptions of multiple linear regression. VIF scores were examined for the test of multicollinearity and showed that there was no issue of multicollinearity between the variables. Additionally, the data was checked for heteroscedasticity and normality of residuals, and there was non-constant variance. To tackle with the problem of heteroscedasticity, transformations are commonly used. However, the use of transformations can have a profound impact on the interpretation of variables and the regression model, as it introduces a new scaling that affects the understanding of parameter estimates (Mueller, 1949). Also, transformations may have minimal or no effect. Consequently, a statistically rigorous approach which is the Huber-White method through Process macro was employed to address the issue of non-constant variance in heteroscedasticity. This approach ensures more accurate inferences, while making only slight changes to the analysis and interpretation of regression models (Astivia & Zumbo, 2019). For the mediation analyses, confidence intervals of 95%, adjusted for bias through bootstrap resampling with 5000 samples, were established. Mediation analyses were performed to understand the mediating effects of parental emotional availability and emotion regulation difficulty on the relationship between helicopter parenting and eating disorder symptoms severity for both mother and father models by using Model 4 and 6 of Process Macro (Hayes, 2018).



CHAPTER IV

RESULTS

In the first part of the result section, descriptive statistics of the study variables will be given. Subsequently, the findings of bivariate correlations among each variable, ANOVA and Kruskal-Wallis tests and the independent groups t-tests will be demonstrated. In the last part of this chapter, the results of the mediation analyses for both mother and father models will be provided.

4.1. Descriptive Statistics

Table 4.1. displays the descriptive statistics such as the mean, standard deviation, and range of the primary variables in the present study.

Means of both helicopter parenting (3.06 for mother and 2.68 for father out of 6.0) and parental emotional availability (3.71 for mother and 2.96 for father out of 6.0) were high on this sample. Besides, the mean of perceived maternal helicopter parenting ($M = 3.06$, $SD = 1.01$) was greater than that of paternal helicopter parenting ($M = 2.68$, $SD = 1.05$), [$t_{(302)} = 7.43$, $p < .001$]. Likewise, the mean of maternal emotional availability ($M = 3.71$, $SD = 1.26$) was higher than that of paternal emotional availability ($M = 2.96$, $SD = 1.40$), [$t_{(302)} = 9.29$, $p < .001$]. Moreover, in this sample, mean of ED severity was 1.66. Considering that a maximum of around 10 points can be obtained from the scale, it is seen that the severity of the eating disorder in the sample was low.

Variable	Range	Min	Max	M	SD
Maternal Helicopter Parenting	5.00	1.00	6.00	3.06	1.01
Paternal Helicopter Parenting	5.00	1.00	6.00	2.68	1.05
Maternal Emotional Availability	5.00	.00	5.00	3.71	1.26

Paternal Emotional Availability	5.00	.00	5.00	2.96	1.40
Emotion Regulation Difficulty	3.88	.00	3.88	1.71	0.88
Eating Disorders Severity	6.32	.00	6.32	1.66	1.40

Table 4.1. Descriptive Statistics for the Variables of the Study

4.2. ANOVA and Kruskal-Wallis Tests

ANOVA and the Kruskal-Wallis tests were conducted accordingly on categorical sociodemographic variables to examine their potential roles of control variables.

Two tests of One-way ANOVA revealed that there were not significant effects of the educational status of both mother [$F_{(2,300)} = 0.45, p = 0.63$] and father [$F_{(2,300)} = 2.14, p = 0.12$] on eating disorder symptoms severity of participants.

Moreover, Kruskal-Wallis tests were conducted in variables where the categories do not have an equal number of participants, and a category contains less than 30 participants such as marital status of parents, residency of participants and living status of participants. Kruskal-Wallis tests indicated that there was not a statistically significant difference on eating disorder symptoms severity between the residencies of participants (i.e., urban and rural) [$(H_{(1)} = .02, p = 0.89)$], marital status of their parents (i.e., psychically together and physically separate) [$(H_{(1)} = 1.81, p = 0.18)$] and living status of participants (i.e., alone, family and other) [$(H_{(2)} = .11, p = 0.95)$].

4.3. Bivariate Correlations

Results of the bivariate correlations indicated that eating disorder symptoms severity was positively correlated with emotion regulation difficulty ($r = .36, p < .001$) while it was negatively related to both maternal ($r = -.22, p < .001$) and paternal emotional availability ($r = -.21, p < .001$). In addition, there was not a significant relationship between either maternal helicopter parenting ($r = .10, p > .05$) or paternal helicopter parenting ($r = -.04, p > .05$) and eating disorder symptoms severity.

In terms of emotion regulation difficulty, paternal emotional availability was negatively associated with the emotion regulation difficulty ($r = -.23, p < .001$). However, there was not a significant relationship between maternal emotional

availability and emotion regulation difficulty ($r = -.08, p > .05$). Also, maternal helicopter parenting was positively related to emotion regulation difficulty ($r = .16, p < .01$), while paternal helicopter parenting was not related to emotion regulation difficulty ($r = -.02, p > .05$).

In general, there were significant relationships between parenting variables. Helicopter parenting of mothers and fathers were found to be positively related ($r = .63, p < .001$). In addition, perceived emotional availability of fathers were positively associated with helicopter parenting of mothers ($r = .12, p < .05$) and fathers ($r = .30, p < .001$) as well as maternal emotional availability ($r = .45, p < .001$). However, maternal helicopter parenting was not significantly related to perceived emotional availability of mothers ($r = .09, p > .05$).

Finally, among continuous demographic variables, BMI were found to be positively related to the eating disorder symptoms severity ($r = .39, p < .001$). Besides, socioeconomic status (SES) was negatively related to emotion regulation difficulty ($r = -.16, p < .01$), while it was positively related to maternal ($r = .22, p < .001$) and paternal emotional availability ($r = .34, p < .001$) which are the potential mediators in the current study. Thus, these findings point out the necessity to control the effect of BMI and SES of participants in further analyses.

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11
1. Age	21.73	2.72	—										
2. Number of Siblings	2.51	1.03	.03	—									
3. Child Order	1.76	0.92	.04	.62***	—								
4. Socioeconomic Status	6.18	1.53	.01	-.14*	-.09	—							
5. BMI	22.19	3.03	.00	-.04	-.03	-.00	—						
6. Maternal Helicopter Parenting	3.06	1.01	-.10	-.12*	-.06	.06	-.11	—					
7. Paternal Helicopter Parenting	2.68	1.05	-.09	-.02	-.03	.04	-.13*	.63***	—				
8. Maternal Emotional Availability	3.71	1.26	-.04	-.02	-.03	.22***	.02	.09	.11	—			
9. Paternal Emotional Availability	2.96	1.40	-.02	-.12*	-.09	.34***	-.05	.12*	.30***	.45***	—		
10. Emotion Regulation Difficulty	1.71	0.88	-.04	-.03	.04	-.16**	-.03	.16**	-.02	-.08	-.23***	—	
11. Eating Disorders Severity	1.66	1.40	.00	-.01	-.01	-.09	.39***	.10	-.04	-.22***	-.21***	.36***	—

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4.2. Correlations for Study Variables

4.4. The Analyses of the Independent Groups T-Test

According to the results of independent groups t-test, there were differences on eating disorder symptoms severity between means in terms of gender ($t_{(301)} = 2.64$, $p < .01$) and the presence of psychological disorders ($t_{(301)} = -3.11$, $p < .05$), while there was not significant differences on eating disorder symptoms severity between educational status of participants (i.e., being an undergraduate student and being a graduate student) [$t_{(301)} = -1.53$, $p = .13$].

That is, women ($M = 1.79$, $SD = 1.45$) demonstrated significantly higher eating disorder scores than men ($M = 1.31$, $SD = 1.19$) (see Table 4.3.). Moreover, the presence of psychological disorders ($M = 2.10$, $SD = 1.58$) resulted in greater eating disorder scores compared to absence of psychological disorders ($M = 1.52$, $SD = 1.31$) (see Table 4.4.). Besides, there were group differences between men and women in terms of perceived maternal emotional availability, which states that men perceive their mother as being more emotionally available than women do.

	Women ($n=223$)		Men ($n=80$)				
Variable	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	$t(301)$	p	Cohen's <i>d</i>
Maternal EA	3.52	1.34	4.23	0.82	-4.44	<.001	-0.58
Paternal EA	2.83	1.39	3.31	1.38	-2.66	.66	-0.35
ERD	1.78	0.88	1.52	0.85	2.30	.71	0.30
Eating Disorders Severity	1.79	1.45	1.31	1.19	2.64	.009	0.34

Note. Maternal EA referred to Maternal Emotional Availability and Paternal EA referred to Paternal Emotional Availability. ERD corresponded to Emotion Regulation Difficulty.

Table 4.3. The Findings of the Independent Groups T-Test Analysis Regarding Gender of Participants

Variable	Presence of psychological disorders (<i>n</i> =73)		Absence of psychological disorders (<i>n</i> =230)		<i>t</i> (301)	<i>p</i>	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Maternal EA	3.50	1.24	3.77	1.26	1.65	.75	.22
Paternal EA	2.46	1.26	3.11	1.41	3.57	.18	.48
ERD	2.19	0.87	1.56	0.82	-5.60	.33	-.75
Eating Disorders Severity	2.10	1.58	1.52	1.31	-3.11	.01	-.42

Note. Maternal EA referred to Maternal Emotional Availability and Paternal EA referred to Paternal Emotional Availability. ERD corresponded to Emotion Regulation Difficulty.

Table 4.4. The Findings of the Independent Groups T-Test Analysis Regarding Presence of Psychological Disorders

As a result of the analyses based on the bivariate correlation and group comparisons, mediation analyses will be conducted while controlling for participants' BMI, gender, SES and presence of psychological disorder. Additionally, as observed in the bivariate correlations, it was evident that both parents influence each other. Therefore, helicopter parenting and perceived emotional availability of the other parent will be controlled in the mediation analyses.

4.5. Mediation Analyses

Mediation analyses were carried out using the PROCESS macro developed by Hayes (2018) for IBM SPSS to test hypotheses and to examine the mediator roles of emotion regulation difficulty and parental emotional availability between helicopter parenting and eating disorder symptoms severity for both mother and father models which were conducted separately. Each mediation analysis included both parental emotional availability and emotion regulation difficulty, which were simultaneously incorporated into analyses.

4.5.a. Mediation Analysis of Maternal Emotional Availability and Emotion Regulation Difficulty

The initial mediation analysis involved maternal helicopter parenting as the independent variable, eating disorder symptoms severity as the dependent variable, and perceived emotional availability of the mother and emotion regulation difficulty of the participant as the mediators.

The study investigated how perceived emotional availability of the mother and emotion regulation difficulty of the adult child mediates the relationship between maternal helicopter parenting and eating disorder symptoms. Helicopter parenting of mother was found to be the significant predictor of emotion regulation difficulty in the participant ($b = .18$, $SE = .06$, $p < .01$), but not of perceived emotional availability of mother ($b = .17$, $SE = .09$, $p > .05$). Moreover, emotion regulation difficulty was not related to perceived emotional availability of mother ($b = .03$, $SE = .04$, $p > .05$), which rejects Hypothesis 4.a. Furthermore, eating disorder symptoms severity was positively related to emotion regulation difficulty in line with the Hypothesis 3 ($b = .47$, $SE = .09$, $p < .001$), while it was negatively related to maternal emotional availability ($b = -.17$, $SE = .06$, $p < .01$), which also supports Hypothesis 2.a. However, neither there was a serial mediation effects of perceived emotional availability of mother and emotion regulation difficulty on the association between helicopter parenting of mother and eating disorder symptoms severity ($b = .00$, 95% CI [-0.01; 0.01]) nor the indirect effect of maternal helicopter parenting on eating disorder symptoms severity through perceived emotional availability of the mother was significant ($b = -.03$, 95% CI [-0.08; 0.01]). Therefore, there was not a mediating role of perceived emotional availability of the mother in the association between maternal helicopter parenting and eating disorder symptoms severity, which partially rejects the Hypothesis 5.a.

In Table 4.5., summary of mediation analysis for variables predicting eating disorder symptoms severity of mother model was presented. Moreover, there was not a significant direct effect of maternal helicopter parenting on eating disorder symptoms severity ($b = .11$, $t = 1.16$, $p > .05$, 95% CI [-0.08; 0.29]), which rejects Hypothesis 1.a. However, the findings demonstrated that there was a significant indirect effect of maternal helicopter parenting on eating disorder symptoms severity through emotion regulation difficulty ($b = .09$, 95% CI [0.02; 0.16]), partially supporting the Hypothesis 5.a. According to Hayes (2009), it was suggested that the independent variable may

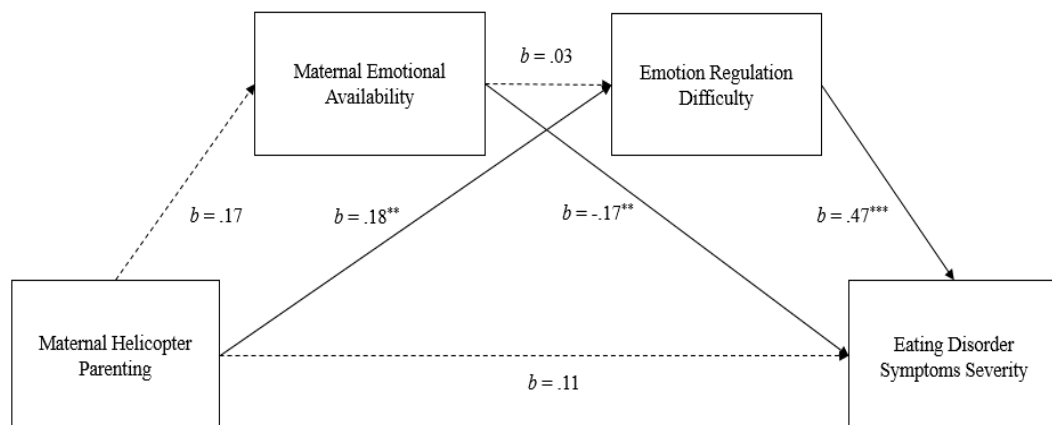
have an indirect impact on the dependent variable through a mediator variable, even when there is no direct association between them. Thus, it can be said that emotion regulation difficulty plays a full mediating role in the relationship between maternal helicopter parenting and eating disorder symptoms severity in university students (see Figure 4.1.).

Variable	SE	95 % CI	<i>b</i>	β	<i>t</i>	<i>p</i>
Maternal HP	.09	[-0.08, 0.29]	.11	.08	1.16	.25
Maternal EA	.06	[-0.29, -0.05]	-.17	-.15	-2.71	.01
ERD	.09	[0.30, 0.64]	.47	.29	5.40	.00
BMI	.02	[0.17, 0.26]	.21	.46	10.15	.00
SES	.05	[-0.09, 0.11]	.01	.01	0.20	.84
Gender	.15	[0.24, 0.85]	.55	.17	3.53	.00
Presence of PD	.17	[-0.06, 0.61]	.28	.08	1.63	.10
Paternal HP	.09	[-0.18, 0.19]	.01	.01	0.09	.93
Paternal EA	.06	[-0.15, 0.10]	-.03	-.03	-.41	.68

Note. Maternal HP referred to Maternal Helicopter Parenting and Paternal HP referred to Paternal Helicopter Parenting. Maternal EA referred to Maternal Emotional Availability and Paternal EA referred to Paternal Emotional Availability. ERD corresponded to Emotion Regulation Difficulty. Presence of PD means to Presence of Psychological Disorder.

Table 4.5. Mediation Analysis Summary for Variables Predicting Eating Disorder Symptoms Severity of Mother Model

Figure 4.1. Maternal Helicopter Parenting and Eating Disorder Symptoms Severity with Emotion Regulation Difficulty as the Mediator



Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

4.5.b. Mediation Analysis of Paternal Emotional Availability and Emotion Regulation Difficulty

The second mediation analysis investigated the relationship between paternal helicopter parenting as the independent variable, eating disorder symptoms severity as the dependent variable, and perceived emotional availability and emotion regulation difficulty of the father as mediators.

In Table 4.6., mediation analysis summary for variables predicting eating disorder symptoms severity of father model was presented. Results indicated that paternal helicopter parenting predicts only perceived emotional availability of father ($b = .41$, $SE = .09$, $p < .001$). It was also found that there was a negative association between perceived emotional availability of father and emotion regulation difficulty of the participant ($b = -.09$, $SE = .04$, $p < .05$), which supports Hypothesis 4.b. The severity of eating disorder symptoms was not related to paternal emotional availability ($b = -.03$, $SE = .06$, $p > .05$) contrary to Hypothesis 2.b, while it was positively related to emotion regulation difficulty ($b = .47$, $SE = .09$, $p < .001$), which supports Hypothesis 3. Besides, there was not a significant direct effect of paternal helicopter parenting on eating disorder symptoms severity ($b = .01$, $t = 0.09$, $p > .05$, 95% CI [-0.17; 0.19]), which rejects Hypothesis 1.b. However, there was a significant indirect effect of paternal helicopter parenting on eating disorder symptoms through paternal emotional availability and emotion regulation difficulty ($b = -.01$, 95% CI [-0.03; -0.00]), which supports Hypothesis 5.b. That is, there was a full serial mediation of paternal emotional availability and emotion regulation difficulty in the relationship between paternal helicopter parenting and eating disorder symptoms severity (see Figure 4.2.).

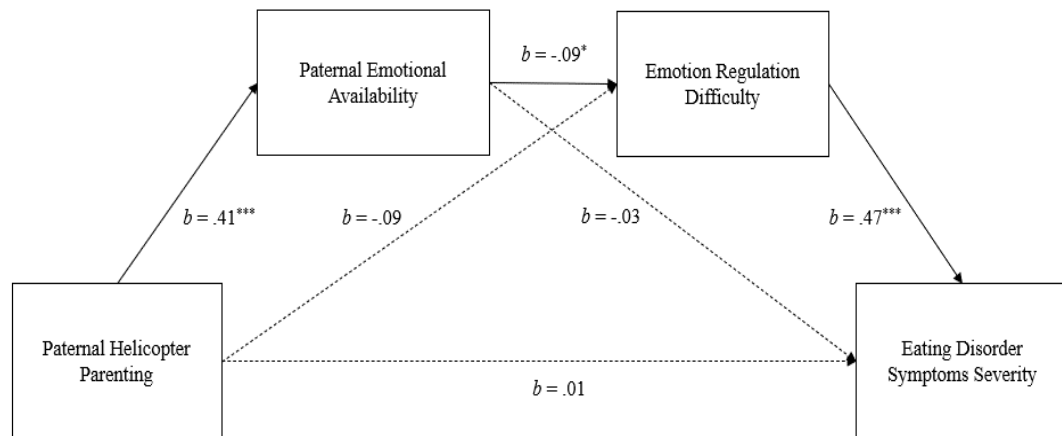
Variable	SE	95 % CI	<i>b</i>	β	<i>t</i>	<i>p</i>
Paternal HP	.09	[-0.17, 0.19]	.01	.01	0.09	.93
Paternal EA	.06	[-0.15, 0.10]	-.03	-.03	-0.41	.68
ERD	.09	[0.30, 0.64]	.47	.29	5.40	.00
BMI	.02	[0.17, 0.26]	.21	.46	10.15	.00
SES	.05	[-0.09, 0.11]	.01	.01	0.20	.84

Gender	.15	[0.24, 0.85]	.55	.17	3.53	.00
Presence of PD	.17	[-0.06, 0.61]	.28	.08	1.63	.10
Maternal HP	.09	[-0.08, 0.29]	.11	.08	1.16	.25
Maternal EA	.06	[-0.29, -0.05]	-.17	-.15	-2.71	.01

Note. Paternal HP referred to Paternal Helicopter Parenting and Maternal HP referred to Maternal Helicopter Parenting. Paternal EA referred to Paternal Emotional Availability and Maternal EA referred to Maternal Emotional Availability. ERD corresponded to Emotion Regulation Difficulty. Presence of PD means to Presence of Psychological Disorder.

Table 4.6. Mediation Analysis Summary for Variables Predicting Eating Disorder Symptoms Severity of Father Model

Figure 4.2. Paternal Helicopter Parenting and Eating Disorder Symptoms Severity with Paternal Emotional Availability and Emotion Regulation Difficulty as the Serial Mediators



Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

To sum up, mediation analyses revealed that as the perception of maternal helicopter parenting increases, the child experiences greater emotion regulation difficulty, which indirectly contributes to the eating disorder symptoms severity. However, as the perception of paternal helicopter parenting increases, the child perceives the father as being more emotionally available, which decreases the child's emotion regulation difficulty, and in turn the severity of eating disorder symptoms decreases.

CHAPTER V

DISCUSSION

The primary objectives of this thesis were to explore the relationship between helicopter parenting and eating disorder symptoms severity and to explore the mediating roles of parental emotional availability and emotion regulation difficulty in this relationship. Thus, the current study hypothesized that after controlling for socio-demographic and other parent-related variables, helicopter parenting and eating disorder symptoms severity would be related. Furthermore, parental emotional availability and emotion regulation difficulty were expected to mediate the relationship between helicopter parenting and eating disorder symptoms severity in either a serial or parallel manner.

To test these hypotheses, the study initially analyzed the bivariate correlations among all variables and conducted ANOVA, Kruskal-Wallis tests and analyses of independent groups t-test. Subsequently, mediation analyses were carried out to examine the mediating roles of parental emotional availability and emotion regulation difficulty in the relationship between helicopter parenting and eating disorder symptoms severity for mothers and fathers separately.

In this section, findings will be discussed in relation to the relevant literature. Additionally, the strengths and clinical implications of the present study will be given. Finally, the limitations of the study will be addressed, and suggestions for future studies will be provided.

5.1. Key Findings of Correlations Among Study Measures

The results of bivariate correlation highlights that the perception of maternal helicopter parenting was higher than that of paternal helicopter parenting among university students. This finding was in line with the literature. In Türkiye, Yılmaz et al. (2020) reported that one-third of mothers and one-seventh of fathers have a helicopter parenting attitude, and mothers exhibit more helicopter parenting behavior compared to fathers. The findings of the studies conducted in the other countries was also similar to those in Türkiye. For instance, Schifffrin et al. (2019) found that individuals at the time of emerging adulthood tend to interpret their mothers as

exhibiting more helicopter parenting behaviors than their fathers. Similarly, a study conducted among a group of women university students revealed that maternal helicopter parenting was more pronounced than paternal helicopter parenting (Cui et al., 2019). As a result, mother's helicopter parenting may be considered a transcultural attitude.

In addition, the results indicate that helicopter parenting of mother and father was positively related, as found by Cui et al. (2019). Furthermore, there was also a positive correlation between emotional availability of mother and father. These findings show that parenting of mother and father are related, which supports the literature. Several studies have provided evidence that parents within the same family exhibit similar parenting behaviors (Barnett et al., 2008; Winsler et al., 2005). Similarly, in a six-year longitudinal study carried out involving mothers, fathers, and their child, enduring impact of parents on each other's parenting was consistently observed (Scott et al., 2018). There are also different approaches to this interdependence between parents. In accordance with Family Systems Theory, there is a notable emphasis on the reciprocal relationship between parenting behaviors in the system of mother-child and the system of father-child, wherein both systems influence each other. That is, the interactions between mothers and fathers can lead to shared parenting strategies, and the parent-child relationships in one system can also impact the parent-child relationships in the other system, creating a complex and interconnected dynamic that shapes the child's overall development and upbringing (Cox & Paley, 1997). Another theory explaining the interdependence between parents is Cognitive Social Learning Theory, as proposed by Bandura (1977), asserts that parents can observe their partner's parenting behavior, leading to the acquisition of various parenting response options through observation. Additionally, they observe their child's reactions to their partner's parenting, enabling them to learn what strategies are effective or ineffective for a specific child. Furthermore, the support and endorsement of a partner's parenting methods can reinforce and strengthen those practices, encouraging parents to continue using them. Conversely, disapproval or criticism of parenting strategies from the other partner can act as punishment, dissuading parents from employing those methods in the future (Schofield et al., 2009). Cognitive models, on the other hand, suggest that competency in parenting relies on the knowledge that parents gain from their daily interactions with their children and

the other partner. Based on these interactions, parents develop cognitive schemas that encompass beliefs about children's understanding and control, the underlying intentions behind children's behavior, parental competence in managing children's actions, and effective approaches to resolving parent-child issues (Dix et al., 1985; Goodnow & Collins, 1990; Bugental, 1992). Consequently, these theories and models indicate that the mutual influence between adult partners over time may significantly impact the type of parenting to which children are exposed. On the contrary, one study suggests an alternative perspective, proposing that the correspondence in parenting behavior between spouses may not necessarily signify a direct influence on their partners' parenting but could instead stem from shared backgrounds or attitudes associated with mate selection (Scott et al., 2018).

Furthermore, the finding of the interaction between the parenting styles of both the mother and father in this study was important because drawing conclusions solely based on the parenting style of a single parent, as seen in some previous studies, may not yield meaningful results. Besides, according to a study conducted by Flouri and Buchanan in 2003, paternal engagement was found to play a significant role in promoting the overall welfare of children. In fact, the study revealed that paternal involvement had a greater impact and surpassed the influence of maternal involvement. This highlights the importance of fathers' active participation and their unique contribution to the well-being of their children. Thus, the current study aimed to observe the influence of both parents on the child, while controlling for the effect of one parent on the other.

In addition, BMI was found to be related to the eating disorder symptoms severity in the current study. As reported in the literature (Rø et al., 2012), it has been observed that as BMI increases, there is a rise in severity of eating disorder symptoms in the sample. Therefore, it can be concluded that a higher BMI is considered a risk factor for the emergence of eating disorders.

The results also showed that as the SES of the family increases, both maternal and paternal emotional availability increases. Similarly, Ziv et al. (1996) reported that mothers with a higher SES provided a more emotional availability for their children compared to mothers with lower SES. This result highlights that SES has been consistently associated with parenting practices and child outcomes (McLoyd, 1998).

Since BMI, SES and helicopter parenting and emotional availability of the other parent were related to the dependent variable and the mediators of the study, they were controlled in mediation analyses.

5.2. Findings of the Independent Groups T-Test

The findings of independent groups t-test indicated that gender of participants and presence of a psychological disorder have a differing effect on eating disorder symptoms severity.

Firstly, consistent with the findings of epidemiological studies (Qian et al., 2021), in the current study women exhibited significantly higher eating disorder scores compared to men. Secondly, the presence of psychological disorders has been found to be related to greater scores on measures of eating disorders in the current study. In other words, individuals who have co-occurring psychological disorders tend to exhibit more severe symptoms of eating disorders. This finding is also consistent with literature, indicating that the occurrence of psychological comorbidity is related to greater severity of eating disorder symptoms (Spindler & Milos, 2007). Thus, in present study, in addition to the BMI and helicopter parenting and emotional availability of the other parent, the effects of gender and presence of a psychological disorder on eating disorder symptoms severity were controlled.

5.3. Effect of Helicopter Parenting on Eating Disorder Symptoms Severity: Exploring Mediation Paths

In the scope of the present study, it was firstly hypothesized that helicopter parenting will be related to the severity of eating disorder symptoms (Hypothesis 1.a and Hypothesis 1.b). The second hypothesis was that parental emotional availability will be related to the severity of eating disorder symptoms (Hypothesis 2.a and Hypothesis 2.b). The third hypothesis was that the difficulty in emotion regulation will be related to the severity of eating disorder symptoms (Hypothesis 3). The fourth hypothesis was that parental emotional availability will be related to the difficulty in emotion regulation (Hypothesis 4.a and Hypothesis 4.b). In addition, the current study proposed that the relationship between helicopter parenting and the severity of eating disorder symptoms would be mediated by two factors: parental emotional availability and difficulty in emotion regulation (Hypothesis 5.a and Hypothesis 5.b). To examine

these hypotheses, mediation analyses were conducted separately for the mother and the father.

Although there is often a reported association between parenting and disordered eating in the literature, contrary to expectations, the present study could not find a significant association among either maternal helicopter parenting or paternal helicopter parenting and eating disorder symptoms severity, which rejects Hypothesis 1.a and Hypothesis 1.b. This may be due to the fact that different parenting styles can lead to varied child outcomes (Baumrind, 1991; Darling & Steinberg, 1993), and the concept of disordered eating refers to a representation of eating disorder symptoms that fall below the threshold for diagnosis and it does not necessarily encompass the condition of eating disorders (National Health Service, 2018). Therefore, implications of parenting and disordered eating in literature does not fully capture the complexity of helicopter parenting and eating disorder symptoms, which may explain the absence of a direct relationship in this study. Besides, there may be mediator variables that play a crucial role between these two variables. For instance, some studies have suggested that adverse parenting styles are often indirectly related to disordered eating and varied depending on the gender of the parent (Hampshire et al., 2022). Hence, it is crucial to explore and identify these potential mediator variables to gain a deeper understanding of helicopter parenting and eating disorder symptoms.

5.3.a. Mediation Path for Maternal Helicopter Parenting and Eating Disorder Symptoms Severity

To gain a deeper understanding of the relationship between maternal helicopter parenting and the severity of eating disorder symptoms in university students, this study examined the mediating roles of maternal emotional availability and the child's difficulty in emotion regulation. The process macro, as proposed by Hayes (2018), was utilized to analyze the mediation model. The hypothesis of the study posited that maternal emotional availability and emotion regulation difficulty would mediate the association between maternal helicopter parenting and eating disorder symptoms severity (Hypothesis 5.a). The findings of the study partially supported this hypothesis.

The results of the mediation analysis indicated that there was no direct relationship between maternal helicopter parenting and eating disorder symptoms severity, and maternal emotional availability did not act as a mediator in this link. However, when the emotion regulation difficulty was included in the model, an

indirect effect of maternal helicopter parenting on eating disorder symptoms severity emerged. Consequently, based on the results of the mediation analysis, it can be inferred that emotion regulation difficulty fully mediates the connection between maternal helicopter parenting and eating disorder symptoms severity. In other words, as maternal helicopter parenting levels increase, adult children are more likely to experience greater difficulty in regulating their emotions, which subsequently leads to higher scores on measures of eating disorder symptoms in university students.

The findings of the present study concerning emotion regulation difficulty are in line with previous research (Wenze et al., 2019) and the existing theories. As explained by the Self-Determination Theory (Ryan & Deci, 2000), helicopter parenting may hinder children from directly engaging with challenging situations and developing effective coping skills. For instance, a mother who immediately steps in when her child faces difficulties in a demanding course or fails to encourage her to resolve conflicts on her own prevents her child from not only finding solutions independently but also from learning how to handle the accompanying emotions such as anxiety, sadness, or frustration, which violates the child's need for autonomy. Moreover, the mother inadvertently communicates to her child that difficult experiences and negative emotions are unsafe, unbearable, and should be avoided or suppressed because she herself may struggle with them on behalf of the child. Consequently, the mother misses an opportunity to demonstrate to the child persistence in pursuing important life goals and promoting a positive perspective towards adversity in which child can develop an emotional competence as another need. Hence, the child, even in their college years, may face difficulties in effectively regulating their emotions in an appropriate manner. Then, as found in the results of the current study and proposed by the Attachment Theory, individuals who struggle with regulating their emotions may resort to using food to escape from or regulate their emotional states. This pattern of using food to cope with emotions increases the risk of developing eating disorders (McCarthy, 1990; Fairburn et al., 1995; Polivy & Herman, 1998; Tasca et al., 2009).

In terms of maternal emotional availability, there are conflicting findings in the literature. Some studies suggest a relationship between parental emotional availability and eating disorders, emphasizing the protective role of parental emotional availability in the onset of EDs (Byely et al., 2012). However, the other studies have not found a

significant correlation between these two variables (Cordero & Israel, 2009; Criscuolo et al., 2023). The discrepancy observed in the literature may arise from differences in measurement instruments and sample characteristics. When it comes to assessing perceived parenting behaviors like parental emotional availability, different studies may utilize different measurement scales or questionnaires, which could potentially yield varying results. Additionally, the diversity in the sample characteristics across various studies might also play a role. Factors like the age range, gender, cultural background, socioeconomic status, and educational level of the participants can influence their perceptions and evaluations of parental behaviors. It is important to consider these factors when interpreting and comparing the findings across different studies. In the present study, a negative relationship was observed between the emotional availability of the mother and eating disorder symptoms severity of the adult child. In line with the findings, Criscuolo et al. (2023) suggests that parental emotional availability can be considered as a component of the emotional context and relational feature within a family that have been demonstrated by research to impact the severity of eating disorder symptoms (Berge et al., 2012; Haines et al., 2010). As a result, the findings of mediation analysis in the present study revealed that maternal emotional availability reduces the child's severity of eating disorder symptoms independently, which highlights the importance of the mother's emotional presence for the adult child.

Furthermore, the findings indicated that maternal emotional availability was not related to the maternal helicopter parenting. That is, when mothers engage in helicopter parenting behaviors, it is not associated with the perception of mother's emotional availability by the child. Likewise, in a thesis study conducted with Turkish university students, no significant association was found between helicopter parenting and the emotional availability of parents (Erkan, 2019).

In addition, in the present study, a relationship between maternal emotional availability and emotion regulation difficulty of the adult child could not be found, unlike the literature indicating a negative link (Ülügen, 2021). While the exact cause for the absence of significant results remains uncertain, one plausible explanation could be that the relatively homogenous nature of the parenting quality within the sample might have hindered the detection of any significant differences in adult children's ability to regulate their emotions. Moreover, this divergence from the literature may be attributable to the difference in the sample characteristics and the

measurement tool. Besides, a potential third variable that contributes to the absence of a significant relationship between maternal emotional availability and the adult child's emotion regulation difficulty could exist such as the personality of the child. For instance, neuroticism is considered an aspect of personality related to the emotion regulation difficulty, and it is suggested to take the neuroticism as a covariate in the emotion regulation studies (Anderson et al., 2021).

The present study also revealed a positive correlation between emotion regulation difficulty and eating disorder symptoms severity, which supports Hypothesis 3. This result was in line with the existing literature. Majority of studies reported a positive connection between emotion dysregulation and symptoms of eating disorders across various diagnostic subtypes (Racine et al. 2017; Trompeter et al., 2022). This finding of the study can be also explained from the point of the Attachment Theory. As the Attachment Theory suggests insecure attachment prevents child from developing emotional competency, which leads child to adopting maladaptive eating patterns as a coping mechanism, such as bingeing and purging, to deal with emotional experiences (Tasca et al., 2009).

To summarize, the present study supported Hypothesis 2.a (i.e., maternal emotional availability will be related to the severity of eating disorder symptoms), Hypothesis 3 (i.e., the difficulty in emotion regulation will be related to the severity of eating disorder symptoms), while Hypotheses 1.a (i.e., maternal helicopter parenting will be related to the severity of eating disorder symptoms) and Hypothesis 4.a (i.e., maternal emotional availability will be related to the difficulty in emotion regulation) were rejected. Also, in line with the existing literature and partially supporting Hypothesis 5.a, this study found that the relationship between maternal helicopter parenting and the severity of eating disorder symptoms was mediated by emotion regulation difficulty of the child. The results of this study offer initial evidence suggesting that maternal helicopter parenting might contribute to eating disorder symptoms by hindering the child's ability to regulate their emotions.

5.3.b. Serial Mediation Path for Paternal Helicopter Parenting and Eating Disorder Symptoms Severity

In order to examine the association between paternal helicopter parenting and the severity of eating disorder symptoms in university students, a mediation analysis was conducted using the Process macro developed by Hayes (2018). The analysis

aimed to explore the influence of paternal emotional availability and emotion regulation difficulty of the child on the relationship between paternal helicopter parenting and the severity of eating disorder symptoms. Based on Hypothesis 5.b, it was expected that paternal emotional availability and emotion regulation difficulty would serve as mediators between paternal helicopter parenting and eating disorder symptoms severity. The findings of the mediation analysis supported this hypothesis and revealed a serial mediation. The results will be comprehensively discussed.

The findings of the mediation analyses indicated that, consistent with existing literature (Hampshire et al., 2022), there was no significant direct relationship between paternal helicopter parenting and the severity of eating disorder symptoms. However, upon incorporating paternal emotional availability and emotion regulation difficulty into the model, an indirect effect of paternal helicopter parenting on eating disorder symptoms severity emerged. Thus, based on the results of the mediation analysis, both paternal emotional availability and emotion regulation difficulty were found to fully and serially mediate the association between paternal helicopter parenting and the severity of eating disorder symptoms. In other words, individuals who perceive higher levels of paternal helicopter parenting tended to perceive greater paternal emotional availability, which reduces levels of emotion regulation difficulty. This connection subsequently leads to a reduction in eating disorder symptoms. Now, the paths of the mediation model will be systematically examined, considering the relevant literature.

First of all, the findings of the mediation analyses demonstrated a positive relationship between paternal helicopter parenting and the perception of paternal emotional availability. In other words, as fathers engage in helicopter parenting behaviors, children perceive their fathers as being more emotionally present and available to them, which was different from the results of maternal helicopter parenting. That is, among university students, it was found that while father's helicopter parenting was perceived as emotionally present, mother's helicopter parenting was not perceived as such. This finding highlights the broadened scope of fathers' impact on their children.

When interpreting the results of this study, it is necessary to evaluate the concept of helicopter parenting that originated in Western literature from the perspective of Turkish culture, as parental attitudes and behaviors cannot be considered independent of culture. From this perspective, the roles that fathers assume

in a traditionally gendered family structure diverge from those of mothers (Roy, 2021). In the Turkish family structure, women spend a significant portion of their time cooking, cleaning, doing dishes, and taking care of the children, while men provide for the family's livelihood and protect them (Bozok, 2018). In other words, while mothers take on the responsibility of caring for children, fathers represent authority and power (Zeybekoğlu, 2013). As discussed in the report "Involved Fatherhood and Its Determinants in Türkiye" of Mother Child Education Foundation (Akçınar, 2017), fathers assume a secondary responsibility in childcare, similar to household chores. In a study, 50% of mothers stated that they were the ones most involved in their child's education, while 20.6% stated that it was their fathers who were involved the most (Özensel, 2004). Although a model of fatherhood has begun to emerge in Türkiye where fathers spend time with their children both inside and outside the home, forming more affectionate and egalitarian relationships (Bozok, 2018), research indicates that generally in the Turkish society, fathers are perceived to have the most important role in providing for the family's livelihood (Güngörmüş Özkardeş & Arkonaç, 1998).

Moreover, in the Turkish society, children spend more time with mothers and develop stronger emotional bonds with them (Sümer, 2006). For example, mothers usually play a dominant role in children's education, making school choices and attending parent-teacher meetings. In a study conducted with adolescents, it was found that emotional availability of mothers was higher than that of fathers (Kahraman & İkiz, 2010). Likewise, Sümer and Güngör (1999) reported that university students perceived their mothers as more accepting/supportive, more controlling, and more participating in their lives than their fathers. Therefore, in the Turkish family structure, while emotional availability and control are expected from mothers, involved and overcontrolling fatherhood does not seem to be the norm. Thus, any overcontrolling actions from fathers may be perceived as expressions of care by their children. For example, in Chinese culture, strict control by fathers is also seen as a form of care (Yoo & Miller, 2011). Similarly, while overprotective parenting based on Western cultures is negatively perceived and has negative effects on children, in Türkiye it is generally seen as positive protection and thus not associated with negative outcomes (Kağıtçıbaşı, 2007; Sümer & Kağıtçıbaşı, 2010). Furthermore, Kağıtçıbaşı (2007) argued that in the Turkish culture and similar collectivist cultures such as Chinese and Korean cultures (Chen-Bouck & Patterson, 2017; Rohner & Pettengill, 1985),

discipline and warmth are perceived as complementary dimensions, not opposing ones. Moreover, it is suggested that in Türkiye, adults have closer relationships with their parents and find it normal for their parents to be involved in their lives, which might be seen as unusual or uncomfortable in individualistic cultures (Telefoncu, 2019).

Furthermore, in the present study, a direct relationship between paternal helicopter parenting and emotion regulation difficulty could not be found, contrary to the findings of the mother model. When examining the roles of mothers and fathers in children's attachment experiences, it is important to consider the influence of cultural factors on parenting practices (Sümer & Güngör, 1999). In collectivistic societies, acceptance/affection and strict control/monitoring behaviors of mothers and fathers may carry different meanings, and the child may attribute different meanings based on who the behavior is coming from, and in turn the different outcomes on the child development appears. Therefore, helicopter parenting of the father could be perceived as the indicator of paternal care by Turkish child, and it does not influence the adult child negatively.

As we moved to the path of paternal emotional availability to emotion regulation difficulty of the child, there was a negative relationship between them. This result is consistent with other studies in the literature. According to Karaoğlu (2018), there is a positive association between fathers' emotional availability and the emotional development of adult daughters. In another study, it was found that fathers' emotional availability negatively predicts emotion regulation difficulty of university students, and the variance explained by paternal emotional availability in predicting emotion regulation difficulties was 6.7% (Ülkümen, 2021). This result was different from the result obtained in the mother model in which in the current study a significant relationship between maternal emotional availability and the child's emotion regulation difficulties could not be found. As suggested that the consequences of emotional availability, which is a crucial aspect of parental interaction with the child, may alter depending on the gender of the parents (Gokce & Yilmaz, 2018). Within a traditional gendered family structure, the roles assumed by fathers differ from those of mothers, which may be one of the reasons for the difference between the results of the mother and the father models. The fathers are more likely to exhibit less nurturing qualities (Caplan & Hall-McCorquodale, 1985), embody a power figure (Knibiehler, 1995) or fulfill the role of financial provider (Craig et al., 2018; Lamb, 2004), thus

demonstrating their availability in these particular ways. Thus, when the perception of emotional availability from the father increases, which is not typically expected from fathers but rather from mothers, it can become a powerful and highly influential impact on the child. As a result, children may feel that their emotions are understood and accepted, leading to a reduction in emotion regulation difficulties.

Unlike the mother model, paternal emotional availability was not directly related to eating disorder symptoms severity of the child. This result was also contrary to the result of bivariate correlations. As indicated in the mediation analysis, the relationship between paternal emotional availability and eating disorder symptoms severity was mediated by emotion regulation difficulty, which shows that bivariate correlation overlooked this indirect link between paternal emotional availability and eating disorder symptoms severity. This finding aligns with previous research indicating that parenting behaviors, including emotional availability, often have an indirect influence on the development of disordered eating patterns (Hampshire et al., 2022).

Lastly, similar to the finding of the mother model and in line with the literature, in the father model, emotion regulation difficulty was negatively related the eating disorder symptoms severity (McCarthy, 1990; Fairburn et al., 1995; Polivy & Herman, 1998). A comprehensive review conducted by Gale et al. (2013) examined the influence of the father-child relationship on the emergence and continuation of eating disorders. The findings revealed that the dynamics between fathers and their children, particularly with daughters, encompass various aspects such as conflict resolution and communication patterns between the father and the child, the level of paternal protection and psychological control, the ability to regulate emotions and maintain self-esteem, and the inclination towards self-perfectionism appear to play a significant role in shaping a child's autonomy and may impact the emergence of harmful eating patterns and psychopathological tendencies.

In summary, in the light of the findings, the present study supported Hypothesis 3 (i.e., the difficulty in emotion regulation will be related to the severity of eating disorder symptoms), and Hypothesis 4.b (i.e., paternal emotional availability will be related to the difficulty in emotion regulation). However, Hypothesis 1.b (i.e., helicopter parenting will be related to the severity of eating disorder symptoms) and Hypothesis 2.b (i.e., paternal emotional availability will be related to the severity of

eating disorder symptoms) were rejected. In addition, this study aligns with previous literature and supports Hypothesis 5.b by the finding that the association between paternal helicopter parenting and the severity of eating disorder symptoms is fully and serially mediated by paternal emotional availability and the child's difficulty in emotion regulation. The results suggest that increased paternal helicopter parenting is linked to a higher perception of paternal emotional availability, which, in turn reduces the severity of eating disorder symptoms by decreasing the child's difficulty to regulate their emotions. These findings indicate that parental attitudes of mother and father can be perceived differently by children. Besides, the way children interpret and respond to their parents' attitudes may be influenced by cultural factors. Cultural norms, values, and expectations can shape parental behaviors and children's perceptions. Therefore, when interpreting and analyzing parental attitudes, it is crucial to take into account the cultural context in which they occur.

5.4. Strengths and Clinical Implications of the Current Study

In the current study, the main objective was to contribute to the existing body of literature that explores the relationship between helicopter parenting and negative mental health outcomes and the mechanisms underlying this association in university students. Current studies are mostly focused on the effect of helicopter parenting on depression and anxiety. However, unlike other studies, this thesis specifically investigates the impact of helicopter parenting on eating disorder symptoms, which fills the gap in the literature about the effects of helicopter parenting on individuals. Besides, the present study is the first known study that searches for the potential mediating roles of parental emotional availability and emotion regulation difficulty in this association. Thus, the present study contributes to expanding the literature on helicopter parenting and possible mediators that play a role in shaping eating psychopathology.

It is also important to consider cultural variations in social norms and the impact of parental involvement on children's development. Different cultures may have diverse expectations regarding the level and type of parental involvement (McElhaney & Allen, 2012). Thus, the findings give information about the patterns of helicopter parenting in the Turkish culture. This thesis represents a pioneering study that offers initial evidence supporting the mediator role of emotion regulation

difficulty between the maternal helicopter parenting and eating disorder symptoms severity in children and the serially mediator roles of paternal emotional availability and emotion regulation difficulty in the association between paternal helicopter parenting and eating disorder symptoms severity. It should not be inferred that increased perception of fathers as emotionally available, as a result of their increased helicopter parenting, is beneficial in terms of reducing the child's emotion regulation difficulties and in turn the severity of eating disorder symptoms. As mentioned earlier, helicopter parenting has many negative effects on a child's development. Therefore, it is important to educate both mothers and fathers about the concept of helicopter parenting and its negative effects on children. Specifically for fathers, it is important to teach them alternative ways of showing interest and affection to their children without engaging in helicopter parenting, and to promote more adaptive behavior patterns and communication strategies. Thus, professionals can assist fathers in developing effective parenting strategies and enhancing their active engagement with their children, regardless of their age.

Furthermore, findings of the current study can illuminate the risk of developing eating disorder symptoms and the age-relevant needs of university students with helicopter parents, such as autonomy, competence and relatedness in line with Self-determination Theory.

The findings of this study also provide guidance for preventive and interventional practices. Preventing helicopter parenting is more effective and easier than trying to convince a helicopter parent to change their attitude (Padilla-Walker & Nelson, 2012), which highlights the importance of parents receiving education on parenting before having children as a part of preventions. Interventions targeting parents' controlling behaviors, overprotectiveness, and unresponsiveness (Berge et al., 2014; Krug et al., 2016; McEwen & Flouri, 2009) should be emphasized. These interventions aim to overcome the persistence of eating disorders symptoms in individuals. Thus, in order to benefit from the current findings, it is important to disseminate the results to parents of university students. To achieve this, psychoeducation and public conferences about the negative effects of helicopter parenting can be organized to inform parents. Informing parents with the effects of helicopter parenting can support helicopter parents in better understanding the needs of their children in a more balanced way of parental control and autonomy.

Additionally, it is recommended to promote "good enough" parenting behaviors that exhibit control and responsiveness that is adequate for the age level of the child, as highlighted in Hautala et al. (2011). These approaches can accelerate the remission of eating disorders symptoms in university students.

In addition, when treating eating disorders, it is crucial for clinicians to adopt a recovery model that focuses on the individual's needs and preferences (Wetzler et al., 2020). Therapeutic techniques for university students with helicopter parents can be used to decrease emotion regulation difficulty and improve adaptive emotion regulation strategies to prevent and overcome eating disorders. For instance, the effectiveness of Emotion Regulation Therapy (ERT) and Acceptance and Commitment Therapy (ACT) in improving emotion regulation has been supported by research (Renna et al., 2017; Hayes et al., 2006). These approaches can be valuable to improve emotion regulation abilities of university students who have helicopter parents. Furthermore, the influence of parents should be taken into consideration, and family-level interventions should be provided (Lock & Le Grange, 2019).

5.5. Limitations of the Present Study and Directions for Future Research

There are also some limitations of the current study. The first one is about the study design. In cross-sectional studies, it is not possible to determine the direction of influence between parenting styles and severity of eating disorder symptoms. While Baumrind (1991) initially viewed parental influence as unidirectional, the understanding of parenting styles has since evolved to recognize mutual and two-sided dynamics, recognizing the child's part in parent-child relationship. (Pinquart & Gerke, 2019; Estlein, 2021). The evidence obtained from a review study suggests that the presence of eating disorders symptoms in young individuals may subsequently impact parenting behaviors (Korotana et al., 2018). Thus, to ascertain causality, future studies should utilize longitudinal methods to examine how helicopter parenting is related to eating disorder symptoms severity and tested for the other age groups as well.

Secondly, the sample of the study is only limited to university students. Thus, the results of the study may not be generalized to the broader population. Besides, the gender distribution was not equal, and the majority of participants were women. Moreover, the education levels of both mother and father were higher compared to the general population in Türkiye, which might also decrease the generalizability of the

study. Hence, it is important for future studies to focus on selecting a sample that is more diverse and representative of the general population. Also, the nonclinical nature of the sample implies that the findings may not be fully applicable to individuals with clinical severity of eating disorders.

In this study, helicopter parenting is based on the perceptions of university students rather than the actual parenting adopted by parents. Thus, future studies can directly measure parenting attitudes on parents themselves and assess the degree of agreement between parents and their children's perceptions.

From a family systems viewpoint, the parenting styles of both mothers and fathers are considered interconnected, and the correlation between their parenting styles plays a significant role in children's well-being, potentially surpassing the individual impact of each parent's parenting style (Gable et al., 1994). Thus, it can be valuable for future studies to consider the unique parenting styles of each parent on the child as a group with a dimensional approach.

Furthermore, future studies can also look for whether helicopter parenting affects categories in the cluster of eating disorder differently from each other. Besides, research could explore whether the emotion regulation strategies utilized by children with helicopter parents differ from those employed by children with non-helicopter parents.

Another drawback of the study is the presentation of scales to all participants in the same order without controlling for the primacy-recency or order effects. The impact of this situation on the results is unknown. Additionally, height and weight information of participants was requested in the demographic information to imply their BMI. However, the reported height/weight information was not validated and relied on self-reporting. Future studies that consider height/weight information can benefit from objective measurements.

Lastly, the present study employed online survey to collect data. In future studies, experimental methods, observations, interviews, focus group studies, and other qualitative research methods and techniques can be used to further explore the impact of helicopter parenting on children in order to capture culturally specific parental characteristics and contextual patterns.

CHAPTER VI

CONCLUSION

This master's thesis aimed to explore the relationship between helicopter parenting and eating disorder symptoms severity, while also investigating the mediator roles of parental emotional availability and emotion regulation difficulty in this link separately for the mother and the father. Through an in-depth analysis and examination of several key findings and insights have been uncovered, shedding light on the complex dynamics between these variables.

The research findings have provided significant contributions to the existing body of knowledge in the field of parenting and eating disorders. The findings have indicated the mediator role of emotion regulation difficulty in the relationship between maternal helicopter parenting and eating disorder symptoms severity in university students. That is, as the perception of maternal helicopter parenting increases, the adult child reports to experience greater difficulty in emotion regulation, which in turn leads to increased severity of eating disorder symptoms in university students. In addition, it has been found that the link between paternal helicopter parenting and eating disorder symptoms severity was mediated serially by paternal emotional availability and emotion regulation difficulty, which means that the more the father displays helicopter parenting, the more emotionally available the child perceives the father, which in turn decreases the child's difficulty in regulating emotions, and finally, the severity of the eating disorder symptoms decreases. While interpreting the results of the parenting, it is crucial to consider cultural norms and values which can have different meanings and outcomes on the child. Children may perceive parental attitudes of mothers and fathers in distinct ways. In Turkish culture, while excessive control is expected from mothers, any similar behaviors of excessive control from fathers may be perceived by children as an expression of care. This could be the reason for such a differing child's outcome of maternal and paternal helicopter parenting in terms of eating disorders.

The results obtained from this study have not only provided empirical evidence for the theoretical frameworks underpinning the study, but also have expanded the existing literature. The findings have practical implications for parents, mental health

professionals and researchers working in the field of eating disorders prevention and intervention. Moreover, the findings highlight the importance of promoting parental emotional availability and enhancing emotion regulation skills of the child as protective factors against the negative effects of helicopter parenting on eating disorder symptoms severity of university students. Lastly, the findings of the current study have also paved the way for future research endeavors in helicopter parenting and eating disorders.



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APPENDIX

APPENDIX A: THE DEMOGRAPHIC INFORMATION FORM

1. Cinsiyetiniz: Kadın ☐ Erkek ☐ Diğer...
2. Yaşınız:
3. Eğitim Durumunuz (Şu an devam etmekte olduğunuz):
Lisans ☐ Yüksek Lisans ☐ Doktora ☐ Öğrenci değilim ☐
4. Hayatınızın büyük çoğunluğunu geçirdiğiniz yer:
Köy ☐ Kasaba ☐ Küçük Şehir ☐ Büyük Şehir ☐
5. Boyunuz kaç metre ve kaç cm?:.....
6. Şu anda kaç kilosunuz?:.....
7. Herhangi bir psikiyatrik rahatsızlığınız (Yeme Bozukluğu dahil) var mı?:
Evet ☐ Hayır ☐
- 7.a. Evet ise psikiyatrik/psikolojik rahatsızlığınızı belirtiniz:
- 7.b. Bu rahatsızlığınızla ilgili destek aldınız mı?
Evet ☐ Hayır ☐
8. Öz anneniz hayatta mı?
Evet ☐ Hayır ☐
Hayatta ise;
8.a. Annenizin eğitim düzeyi:
☐ Okuryazar değil ☐ Okuryazar ☐ İlkokul mezunu ☐ Ortaokul mezunu ☐ Lise mezunu ☐
Yüksekokul mezunu ☐ Üniversite mezunu ve üzeri
9. Öz babanız hayatta mı?
Evet ☐ Hayır ☐
Hayatta ise;
9.a. Babanızın eğitim düzeyi:
☐ Okuryazar değil ☐ Okuryazar ☐ İlkokul mezunu ☐ Ortaokul mezunu ☐ Lise mezunu ☐
Yüksekokul mezunu ☐ Üniversite mezunu ve üzeri

10. Anne-babanız;

Birlikte ☐ Boşanmış ☐ Yasal olarak evli ama ayrı yaşıyorlar ☐ Boşanmış ama aynı evde yaşıyorlar ☐

11. Halen kiminle birlikte yaşıyorsunuz?

Aile ☐ Ev arkadaşı ☐ Yurt arkadaşı ☐ Partner ☐ Yalnız

12. Siz dahil kaç kardeşsiniz?:

13. Siz ailenizin kaçınıcı çocuğusunuz?:

14. Aşağıdaki merdivenin Türkiye'deki insanların durduğu yeri temsil ettiğini düşünün.

Merdivenin tepesindekiler her şeyin en iyisine (en çok paraya, en iyi eğitime ve en saygın mesleklere) sahip olanlar.

Merdivenin en altındakiler ise, en kötü koşullara sahip olanlar (en az paraya, en az eğitime ve en az sayılan mesleklere sahip olanlar ya da hiçbir işi olmayanlar).

Bu merdivende daha yüksek bir konuma sahip olmanız en tepedeki insanlara daha yakın olduğunuz; daha aşağıda olmanız ise en alttaki insanlara daha yakın olduğunuzu gösterir.

Siz bugün kendinizi ve ailenizi hangi basamakta görüyorsunuz?

1—2—3—4—5—6—7—8—9—10



APPENDIX B: THE HELICOPTER PARENTING BEHAVIORS QUESTIONNAIRE (HPBQ) – MOTHER FORM

Aşağıda annenizle ilgili çeşitli ifadeler yer almaktadır. Aşağıdaki ifadeleri siz büyürken yanınızda olan **annenizi düşünerek** 1 (kesinlikle katılmıyorum) ile 6 (kesinlikle katılıyorum) arasında işaretleyiniz. Bu ölçekte doğru-yanlış ya da verilmesi gereken bir yanıt söz konusu değildir. Bu nedenle, her bir ifadeyi lütfen kendi değerlendirmenize göre işaretleyiniz.

(Katılmıyorum) (Biraz katılıyorum) (Kesinlikle katılıyorum)

1-----2-----3-----4-----5-----6

(Kesinlikle katılmıyorum) (Biraz katılmıyorum) (Katılıyorum)

	Kesinlikle katılmıyorum					Kesinlikle katılıyorum
1. Annem hangi bölümü seçtiğim/seçeceğim konusunda söz hakkına sahipti/sahip olacaktır.	1	2	3	4	5	6
2. Annem yaşadığım herhangi bir akademik sorunu hocamla konuşmam için beni teşvik eder.	1	2	3	4	5	6
3. Annem benim çalışma programımı takip eder.	1	2	3	4	5	6
4. Annemle aynı evdeyken, her akşam eve en geç saat kaçta geleceğim bellidir.	1	2	3	4	5	6
5. Annem market alışverişini ekonomik bir şekilde nasıl yapacağım konusunda bana ipuçları verir.	1	2	3	4	5	6
6. Annem beni kendi kararlarımı almam ve yaptığım seçimlerin sorumluluğunu üstlenmem konusunda cesaretlendirir.	1	2	3	4	5	6
7. Annem nerede olduğumu bilmek için düzenli olarak onu aramamı ya da ona mesaj atmamı ister.	1	2	3	4	5	6
8. Annem birlikte yaşadığım arkadaşlarım ya da diğer arkadaşlarımla olan her türlü kişiler arası sorunun üstesinden kendi başıma gelmem için beni teşvik eder.	1	2	3	4	5	6
9. Eğer adil olmadığımı düşündüğüm düşük bir not alsaydım, annem hocayı arardı.	1	2	3	4	5	6
10. Annem beslenme düzenimi takip eder.	1	2	3	4	5	6
11. Annem kiminle vakit geçirdiğimi takip eder.	1	2	3	4	5	6
12. Annem kendi hesabımı tutmam ve ekonomimi yönetmem konusunda beni teşvik eder.	1	2	3	4	5	6
13. Annem okul performansımı takip etmek için beni arar (örn., okulda nasılım, notlarım nasıl vb.)	1	2	3	4	5	6
14. Eğer oda/ev arkadaşımın bir sorun yaşasaydı, annem müdahale etmeye çalışırdı.	1	2	3	4	5	6
15. Annem derslerimi kendim seçmem konusunda beni cesaretlendirir.	1	2	3	4	5	6

APPENDIX C: THE HELICOPTER PARENTING BEHAVIORS QUESTIONNAIRE (HPBQ) – FATHER FORM

Aşağıda babanızla ilgili çeşitli ifadeler yer almaktadır. Lütfen aşağıdaki ifadeleri siz büyürken yanınızda olan **babanızı düşünerek** 1 (kesinlikle katılmıyorum) ile 6 (kesinlikle katılıyorum) arasında işaretleyiniz. Bu ölçekte doğru-yanlış ya da verilmesi gereken bir yanıt söz konusu değildir. Bu nedenle, her bir ifadeyi lütfen kendi değerlendirmenize göre işaretleyiniz.

(Katılmıyorum) (Biraz katılıyorum) (Kesinlikle katılıyorum)

1-----2-----3-----4-----5-----6

(Kesinlikle katılmıyorum) (Biraz katılmıyorum) (Katılıyorum)

	Kesinlikle katılmıyorum					Kesinlikle katılıyorum
1. Babam hangi bölümü seçtiğim/seçeceğim konusunda söz hakkına sahipti/sahip olacaktır.	1	2	3	4	5	6
2. Babam yaşadığım herhangi bir akademik sorunu hocamla konuşmam için beni teşvik eder.	1	2	3	4	5	6
3. Babam benim çalışma programımı takip eder.	1	2	3	4	5	6
4. Babamla aynı evdeyken, her akşam eve en geç saat kaçta geleceğim bellidir.	1	2	3	4	5	6
5. Babam market alışverişini ekonomik bir şekilde nasıl yapacağım konusunda bana ipuçları verir.	1	2	3	4	5	6
6. Babam beni kendi kararlarımı almam ve yaptığım seçimlerin sorumluluğunu üstlenmem konusunda cesaretlendirir.	1	2	3	4	5	6
7. Babam nerede olduğumu bilmek için düzenli olarak onu aramamı ya da ona mesaj atmamı ister.	1	2	3	4	5	6
8. Babam birlikte yaşadığım arkadaşlarım ya da diğer arkadaşlarımla olan her türlü kişiler arası sorunun üstesinden kendi başıma gelmem için beni teşvik eder.	1	2	3	4	5	6
9. Eğer adil olmadığını düşündüğüm düşük bir not alsaydım, babam hocayı arardı.	1	2	3	4	5	6
10. Babam beslenme düzenimi takip eder.	1	2	3	4	5	6
11. Babam kiminle vakit geçirdiğimi takip eder.	1	2	3	4	5	6
12. Babam kendi hesabımı tutmam ve ekonomimi yönetmem konusunda beni teşvik eder.	1	2	3	4	5	6
13. Babam okul performansımı takip etmek için beni arar (örn., okulda nasılım, notlarım nasıl vb.)	1	2	3	4	5	6
14. Eğer oda/ev arkadaşımın bir sorun yaşasaydı, babam müdahale etmeye çalışırdı.	1	2	3	4	5	6
15. Babam derslerimi kendim seçmem konusunda beni cesaretlendirir.	1	2	3	4	5	6

APPENDIX D: THE LUM EMOTIONAL AVAILABILITY OF PARENTS (LEAP)

Aşağıda anne ve babanızla ilgili çeşitli ifadeler yer almaktadır. Her bir ifade anneniz ve babanızın size nasıl davrandığıyla ilgilidir. Her bir ifadeyi dikkatlice okuyarak siz büyüken yanınızda olan anne ve babanızın size yönelik davranışlarını 6 dereceli ölçek üzerinden değerlendiriniz. Bu ölçekte doğru-yanlış ya da verilmesi gereken bir yanıt söz konusu değildir. Bu nedenle, her bir ifadeyi lütfen kendi değerlendirmenize göre işaretleyiniz Hem anneniz hem de babanız için işaretleme yapınız.

(Nadiren) (Sık sık) (Her zaman)

1-----2-----3-----4-----5-----6

(Hiçbir zaman) (Bazen) (Çok sık)

	Anne						Baba					
1. Bana destek olur.	1	2	3	4	5	6	1	2	3	4	5	6
2. Üzgün olduğumda beni teselli eder (örneğin, mutsuz olduğumda kendimi daha iyi hissetmemi sağlar).	1	2	3	4	5	6	1	2	3	4	5	6
3. Beni önemseddiğini gösterir.	1	2	3	4	5	6	1	2	3	4	5	6
4. Benimle içten bir şekilde ilgilendiğini gösterir (örneğin, bana değer verir ve benim için endişelenir).	1	2	3	4	5	6	1	2	3	4	5	6
5. Benim için önemli olan şeyleri hatırlar.	1	2	3	4	5	6	1	2	3	4	5	6
6. Onunla ne zaman konuşmak istesem uygundur.	1	2	3	4	5	6	1	2	3	4	5	6
7. Bana ilgisini gösterecek şekilde sorular sorar.	1	2	3	4	5	6	1	2	3	4	5	6
8. Benimle, gerçekten istediği için vakit geçirir.	1	2	3	4	5	6	1	2	3	4	5	6
9. Sorunlarım, sıkıntılarım konusunda benimle konuşmaya isteklidir.	1	2	3	4	5	6	1	2	3	4	5	6
10. Sevdiğim şeylerle ilgili benimle konuşur.	1	2	3	4	5	6	1	2	3	4	5	6
11. Düşüncelerimi önemser.	1	2	3	4	5	6	1	2	3	4	5	6
12. Duygusal olarak erişilebilirdir (Varlığını duygusal olarak hissederim).	1	2	3	4	5	6	1	2	3	4	5	6
13. İstenen biri olduğumu hissettirir.	1	2	3	4	5	6	1	2	3	4	5	6
14. Beni takdir eder, över (örneğin, benimle ilgili olumlu şeyler söyler).	1	2	3	4	5	6	1	2	3	4	5	6
15. Anlayışlıdır.	1	2	3	4	5	6	1	2	3	4	5	6

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

Aşağıdaki ifadelerin size ne sıklıkla uyduğunu, her ifadenin yanında yer alan 5 dereceli ölçek üzerinden değerlendiriniz.

	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 hissettiğim işlerimi bitirmekte zorlanırım.					
4. Kendimi kötü hissettiğim kontrolde çıkarım.					
5. Kendimi kötü hissettiğim 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 kontrolde çıktığım korkusu yaşarım.					
9. Kendimi kötü hissettiğim bu duygudan dolayı kendimden utanırım.					
10. Kendimi kötü hissettiğimde zayıf biri olduğum duygusuna kapılırım.					
11. Kendimi kötü hissettiğim davranışlarımı kontrol etmekte zorlanırım.					
12. Kendimi kötü hissettiğimde daha iyi hissetmem için yapabileceğim hiçbir şey olmadığına inanırım.					
13. Kendimi kötü hissettiğim böyle hissettiğim için kendimden rahatsız olurum.					
14. Kendimi kötü hissettiğim kendimle ilgili olarak çok fazla endişelenmeye başlarım.					
15. Kendimi kötü hissettiğim başka bir şey düşünmekte zorlanırım.					
16. Kendimi kötü hissettiğim duygularım dayanılmaz olur.					

APPENDIX F: THE EATING DISORDER EXAMINATION QUESTIONNAIRE (EDE-Q)

Aşağıdaki sorular sadece son 4 hafta ile ilgilidir. Lütfen her soruyu dikkatlice okuyunuz ve tüm soruları yanıtlayınız.

1'den 12'ye kadar olan sorular: Lütfen sizin için uygun olan sayıyı seçiniz. Soruların sadece son dört haftayı içerdiğini (28 gün) unutmayınız.

	Son 28 günün kaçında...	Hiçbir inde	1 -5	6 -12	13 - 15	16 - 22	23 -27	Her gün
1-	Kilonuzu ya da bedeninizin şeklini değiştirmek amacıyla yiyecek miktarınızı kasıtlı olarak sınırlandırmaya çalıştınız? <i>(Başarılı olup olmadığınız önemli değildir.)</i>	0	1	2	3	4	5	6
2-	Bedeninizin şeklini ya da kilonuzu değiştirmek amacıyla uzun bir süre <i>(uyanık olduğunuz 8 saat boyunca ya da daha fazla bir süre için)</i> hiçbir şey yemediğiniz oldu?	0	1	2	3	4	5	6
3-	Bedeninizin şeklini ya da kilonuzu değiştirmek amacıyla hoşlandığınız yiyecekleri beslenme düzeninizden çıkarmaya çalıştınız? <i>(Başarılı olup olmadığınız önemli değildir.)</i>	0	1	2	3	4	5	6
4-	Bedeninizin şeklini ya da kilonuzu değiştirmek amacıyla yemenizle ilgili (örn. kalori sınırlandırması) belli kurallara uymaya çalıştınız? <i>(Başarılı olup olmadığınız önemli değildir.)</i>	0	1	2	3	4	5	6
5-	Bedeninizin şeklini ya da kilonuzu etkilemek amacıyla boş bir mideye sahip olmak için belirgin bir arzu duydunuz?	0	1	2	3	4	5	6
6-	Tamamen düz bir karına sahip olmak için belirgin bir arzu duydunuz?	0	1	2	3	4	5	6
7-	<u>Yiyecek, yemek yeme ya da kalorilerle ilgili düşünmenin, ilgilendiğiniz konulara (örn. çalışma, bir konuşmayı takip etme ya da okuma) yoğunlaşmanızı çok zorlaştırdığı oldu?</u>	0	1	2	3	4	5	6

8-	Bedeninizin şekli ve kilovla ilgili düşünmenin, ilgilendiğiniz konulara (örn. İşinize, bir konuşmayı takip etmenize ya da okumanıza) yoğunlaşmanızı çok zorlaştırdığı oldu?	0	1	2	3	4	5	6
9-	Yemek yemeye ilgili kontrolü kaybetmekten belirgin biçimde korktuğunuz oldu?	0	1	2	3	4	5	6
10-	Kilo alabileceğinizden belirgin bir biçimde korkunuz?	0	1	2	3	4	5	6
11-	Kendinizi şişman hissettiniz?	0	1	2	3	4	5	6
12-	Kilo vermek için güçlü bir arzunuz oldu?	0	1	2	3	4	5	6

13'ten 18'e kadar olan sorular: Lütfen sağdaki boşluğa sizin için uygun olan sayı yazınız. Soruların yalnızca son dört haftaya yönelik olduklarını (28 güne) hatırlayınız.

	Son dört hafta içinde (28 gün)...	
13-	Son 28 gün içinde, kaç kere, başka insanların alışılmadık miktarda fazla (şartlara göre) olarak tanımlayacakları biçimde yemek yediniz?	
14-	Bu süre içinde kaç kere yemek yemenizle ilgili kontrolü kaybetme hissine kapıldınız (yediğiniz sırada)?	
15-	Son 28 günün kaç GÜNÜNDE aşırı yemek yeme nöbetleri ortaya çıktı (örn. alışılmadık miktarda fazla yemek yediğiniz ve o sırada kontrolü kaybettiğiniz duygusunu yaşadınız)?	
16-	Son 28 gün içinde, bedeninizin şekli ya da kilonuzu kontrol amacıyla, kaç kere kendinizi kusturdunuz?	
17-	Son 28 gün içinde, bedeninizin şekli ya da kilonuzu kontrol amacıyla, kaç kere müşhil (bağırsak çalıştırıcı) kullandınız?	
18-	Son 28 gün içinde, kilonuzu, bedeninizin şeklini ya da yağ miktarınızı kontrol etmek, kalorileri yakmak amacıyla, kaç kere “kendinizi kaybedercesine” ya da “saplantılı” biçimde egzersiz yaptınız?	

19'dan 21'e kadar olan sorular: Lütfen sizin için uygun olan sayıyı seçiniz. Lütfen bu sorular için "tıkınırcasına yeme" teriminin, mevcut koşullarda başkalarına göre alışılmadık miktarda ve kontrolü kaybetme duygusuyla beraber fazla yemeyi ifade ettiğini göz önünde bulundurunuz.

19-	Son 28 gün içinde, kaç kere gizlice (örn. saklanarak) yemek yediniz? (Tıkınırcasına yeme durumlarını saymayınız.)	Hiçbirinde	1 -5 gün	6 -12 gün	13 -15 gün	16 -22 gün	23 -27 gün	Her gün
		0	1	2	3	4	5	6
20-	Yemek yediğiniz zaman bedeninizin şeklini ya da kilonuzu etkilediği için ne oranda kendinizi suçlu hissettiniz (hata yaptığınızı hissettiniz)? (Tıkınırcasına yemek yeme durumlarını saymayınız.)	Hiçbir zaman	Nadiren	Yarıdan az	Yarıyarıya	Yarıdan fazla	Çoğun zaman	Her zaman
		0	1	2	3	4	5	6
21-	Son 28 gün içinde, başkalarının sizi yemek yerken görmesiyle ilgili ne kadar endişelendiniz? (Tıkınırcasına yeme durumlarını saymayınız.)	Hiç	Biraz		Orta		Önemli ölçüde	
		0	1	2	3	4	5	6

22'den 28'e kadar olan sorular: Lütfen sizin için uygun olan sayıyı seçiniz. Soruların yalnızca son dört haftaya yönelik olduklarını (28 güne) hatırlayınız.

		Hiç	Biraz	Orta	Önemli ölçüde			
22-	<u>Kilonuz</u> , kişi olarak kendiniz hakkında düşüncenizi ve yargınızı etkiledi mi?	0	1	2	3	4	5	6
23-	<u>Bedeninizin şekli</u> , kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi mi?	0	1	2	3	4	5	6
24-	Önümüzdeki dört hafta boyunca, haftada 1 kez tartılmanız istense (ne daha sık ne daha seyrek), bu sizi ne kadar üzerdi?	0	1	2	3	4	5	6
25-	<u>Kilonuzdan</u> ne derece memnun değilsiniz?	0	1	2	3	4	5	6
26-	<u>Bedeninizin şeklinden</u> ne derece memnun değilsiniz?	0	1	2	3	4	5	6
27-	Bedeninizi görmekten ne kadar rahatsız oluyorsunuz (örn. aynada, mağazanın camında, soyunurken, banyo ya da duş yaparken)?	0	1	2	3	4	5	6
28-	<u>Başkalarının</u> bedeninizin şeklini görmesinden ne derece rahatsız oluyorsunuz? (örn. Soyunma odalarında, yüzerken ya da dar elbiseler giyerken)	0	1	2	3	4	5	6

APPENDIX G: APPROVAL OF TOBB ETU HUMAN RESEARCH EVALUATION BOARD

Evrak Tarih ve Sayısı: 26.08.2022-E.28688



T.C.
TOBB EKONOMİ VE TEKNOLOJİ ÜNİVERSİTESİ
İnsan Araştırmaları Değerlendirme Kurulu

Sayı : E-27393295-100-28688
Konu : 2022-44 numaralı başvuru

26.08.2022

Sayın Prof. Dr. Ayşe Nuray KARANCI

İnsan Araştırmaları Değerlendirme Kurulu'na etik yönden değerlendirilmek üzere sunmuş olduğumuz 2022-44 kayıt numaralı "Üniversite Öğrencilerinde Algılanan Anne ve Baba Helikopter Ebeveynlik Davranışları ile Yeme Bozuklukları Psikopatolojisi Arasındaki İlişki: Duygu Düzenleme Güçlüğü ve Algılanan Ebeveyn Duygusal Erişilebilirliğinin Rolü" başlığını taşıyan projeniz etik yönden uygun görülerek onaylanmasına karar verilmiştir.
Bilgilerinizi rica ederiz

Prof. Dr. Tayyibe Nur ÇAĞLAR
Kurul Başkanı

Bu belge, güvenli elektronik imza ile imzalanmıştır.

Belge Doğrulama Kodu : BSPEVCA15
Sığınantı Caddesi No:43 06560 Sığınantı/Ankara
Telefon No:(0312) 292-4000 Faks No:(0312) 287-1946
e-Posta: bilgi@etu.edu.tr İnternet Adresi: www.etu.edu.tr
Kep Adresi: tobbetu@hu01.kep.tr

Belge Doğrulama Adresi : <https://www.turkiye.gov.tr/tobb-universitesi-obyis>

Bilgi için: Nimet Zorlu
Sekreter

Bu belge 5070 sayılı Elektronik İmza Kanununun 5. Maddesi gereğince güvenli elektronik imza ile imzalanmıştır.

APPENDIX H: INFORMED CONSENT FORM

TOBB EKONOMİ VE TEKNOLOJİ ÜNİVERSİTESİ İNSAN ARAŞTIRMALARI İÇİN AYDINLATILMIŞ ONAM FORMU

(Araştırmacının Açıklaması)

“Üniversite Öğrencilerinde Algılanan Anne ve Baba Helikopter Ebeveynlik Davranışları ile Yeme Bozuklukları Psikopatolojisi Arasındaki İlişki: Duygu Düzenleme Güçlüğü ve Algılanan Ebeveyn Duygusal Erişilebilirliğinin Rolü” başlıklı bir araştırma yapmaktayız. Sizin de bu araştırmaya katılmanızı öneriyoruz. Ancak hemen söyleyelim ki bu araştırmaya katılıp katılmamakta serbestsiniz. Çalışmaya katılım gönüllülük esasına dayalıdır. Kararınızdan önce araştırma hakkında sizi bilgilendirmek istiyoruz. Bu bilgileri okuyup anladıktan sonra araştırmaya katılmak isterseniz formu imzalayınız. Bu araştırma TOBB ETÜ Sosyal Bilimler Fakültesi Klinik Psikoloji Yüksek Lisans Programı tarafından gerçekleştirilecektir. Bu araştırmayı yapmak istememizin amacı, kişinin algıladığı ebeveyn tutumları, duygu düzenleme güçlüğü ve problemli yeme davranışı arasındaki ilişki hakkında bilgi toplamaktır. Bu çalışmaya katılımınız araştırmanın başarısı için önemlidir. Eğer araştırmaya katılmayı kabul ederseniz, kişisel bilgi formunu ve yaklaşık 15 dakikalık çevrimiçi bir ankette yer alan soruları yanıtlamanız beklenmektedir. Bu çalışmaya katılmanız için sizden herhangi bir ücret istenmeyecektir. Çalışmaya katıldığınız için size ek bir ödeme de yapılmayacaktır. Bu çalışmaya katılmayı reddedebilirsiniz. Bu araştırmaya katılmak tamamen isteğe bağlıdır. Çalışmanın herhangi bir aşamasında onayınızı çekme hakkına da sahipsiniz.

(Katılımcının Beyanı)

Prof. Dr. A. Nuray Karancı ve Semiha Çoban tarafından TOBB ETÜ Sosyal Bilimler Fakültesi Klinik Psikoloji Yüksek Lisans Programı’nda bir araştırma yapılacağı belirtilerek bu araştırma ile ilgili yukarıdaki bilgiler bana aktarıldı. Bu bilgilerden sonra böyle bir araştırmaya “katılımcı” olarak davet edildim. Eğer bu araştırmaya katılırsam araştırmacı ile aramda kalması gereken bana ait bilgilerin gizliliğine bu araştırma sırasında da büyük özen ve saygı ile yaklaşılacağı, araştırma sonuçlarının eğitim ve bilimsel amaçlarla kullanımı sırasında kişisel bilgilerimin özenle korunacağı konusunda bana yeterli güven verildi. Bu araştırmaya katılmak zorunda değilim ve katılmayabilirim. Araştırmaya katılmam konusunda zorlayıcı bir davranışla karşılaşmış değilim. Araştırmanın yürütülmesi sırasında herhangi bir sebep göstermeden çekilebilirim. Ancak araştırmacıları zor durumda bırakmamak için araştırmadan çekileceğimi önceden bildirmemim uygun olacağının bilincindeyim. Araştırma için yapılacak harcamalarla ilgili herhangi bir maddi sorumluluk altına girmiyorum. Bana da bir ödeme yapılmayacaktır. Araştırma uygulamasından kaynaklanan nedenlerle herhangi bir sorunun ortaya çıkması halinde, sorunun çözülmesi ile ilgili gerekli müdahalenin yapılacağı konusunda bana güvence verildi. Araştırma ile ilgili bir sorum olduğunda, Prof. Dr. A. Nuray Karancı’yı no’lu telefonundan arayabileceğimi biliyorum. Bana yapılan tüm açıklamaları ayrıntılarıyla anlamış bulunmaktayım. Kendi başıma belli bir düşünme süresi sonunda adı geçen bu araştırma projesinde “katılımcı” olarak yer alma kararımı aldım. Bu konuda yapılan daveti büyük bir memnuniyet ve gönüllülük içerisinde kabul ediyorum. Karşılıklı imzalanan bu form kağıdının bir kopyası bana verilecektir.

Katılımcı (Ad, soyad, adres, telefon ve imza) **Araştırmacılar** (Ad, soyad, adres, telefon ve imza)