

The Relationship Between Social Problem Solving and Eating Pathology: Parallel and Serial Mediating Roles of Emotional Eating and Intuitive Eating

by

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The Relationship Between Social Problem Solving and Eating Pathology: Parallel and Serial Mediating Roles of Emotional Eating and Intuitive Eating

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ABSTRACT

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This study suggests that a tendency to alter dietary intake to cope can establish a ground for eating pathology. Coping-related eating measures, emotional eating, and intuitive eating were examined as mediators in the relationship between social problem solving and eating pathology. A convenience sample of 377 university students aged between 18 and 30 were recruited. Parallel and serial mediation analyses were conducted. Results indicated that intuitive eating and emotional eating fully mediated the relationship between social problem solving and eating pathology, both independently and sequentially. Findings suggest that deficiencies in effectively dealing with issues in daily life might lead to altering dietary intake as an attempt to cope, which might ultimately lead to eating pathology. The associations between eating pathology components and maladaptive problem-solving style are also discussed within the perspective of the transdiagnostic eating disorder model.

ÖZETÇE

Sosyal Sorun Çözme ve Yeme Patolojisi İlişkisinde Duygusal Yeme ve Sezgisel

Yemenin Aracı Roller

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“Sosyal Sorun Çözme ve Yeme Patolojisi İlişkisinde Duygusal Yeme ve Sezgisel Yemenin Aracı Roller” isimli tez çalışması, temelde, yemek yeme davranışını değişimlemenin bir başa çıkma yöntemi olarak kullanılması eğiliminin yeme patolojisine zemin hazırlayabileceğini önermektedir. Duygusal ve sezgisel yeme kavramları, başa çıkma davranışı ile ilişkili yeme değişkenleri olarak belirlenmiş, söz konusu değişkenler çalışmada birer aracı hâlinde atanmış ve rolleri sosyal sorun çözme becerileri ile yeme patolojisi bağlamında incelenmiştir. Araştırmanın amacına uygun olarak paralel ve seri aracı değişken analizlerini yapabilmek adına kolay ulaşılabilir örnekleme yöntemi ile 18 ilâ 30 yaşları arasındaki 377 kişilik bir veri setine ulaşılmıştır. Sezgisel yeme ve duygusal yeme kavramlarının sosyal sorun çözme ve yeme patolojisi arasındaki ilişkide, hem bağımsız hem de ardışık yollar üzerinde tam aracı etkisi gözlemlenmiştir. Çalışmada elde edilen bulgular, günlük hayattaki sorunlarla etkili bir şekilde başa çıkmadaki eksikliklerin kişileri, bir başa çıkma yöntemi olarak beslenmeyi değiştirmeye itebileceğine ve bu durumun da yeme patolojisine zemin hazırlayabileceğine işaret etmektedir. İlâveten, yeme patolojisi faktörleri ile uyumsuz sorun çözme tarzları arasındaki çeşitli ilişkiler yeme bozukluklarının tanımlararası modeli kapsamında tartışılmıştır.

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ABBREVIATIONS

PPO	Positive Problem Orientation
NPO	Negative Problem Orientation
RPS	Rational Problem-Solving Style
APS	Avoidant Problem-Solving Style
IPS	Impulsive/Careless Problem-Solving Style
SPSI-R	Social Problem-Solving Inventory - Revised
IES-2	Intuitive Eating Scale - 2
TEES	Turkish Emotional Eating Scale
EDEQ-13	Eating Disorder Examination Questionnaire - 13
CBT-E	Enhanced Cognitive Behavioral Therapy
NCB	Non-Compensatory Weight and Shape Control Behaviors

Chapter 1:

INTRODUCTION

Eating is an essential part of our lives: not only does it allow an organism to receive energy and nutrients, but it is also a behavior and drive shared by every member of our species. Our relationship with food dates back to the very beginning of our existence. We learned about the relationship between seasons and food, and that allowed us to utilize our memory (Allen, 2012/2021). Furthermore, we adopted a tendency to categorize entities by classifying nutrients as edible and non-edible. Food and eating have even been attached to rituals, belief systems, and cultural identities (Mintz & Du Bois, 2002).

Just as our living conditions change, so does our relationship with food. With the Industrial Revolution, the availability of low-cost dietary energy increased (Caballero, 2007). Food is now appraised as always available; thus, using it to cope with issues is easy, as eating is the most natural way for us to feel satisfaction. Considering that problems are an essential aspect of our lives, using eating and eating-related behavior to cope with them has significant importance in addressing our psychological well-being. This study investigates the relationship between problem solving and eating pathology in this context. Additionally, the mechanisms through which this influence operates are analyzed.

1.1 Social Problem-Solving Skills

Problem solving is a self-directed process that emerges in response to a stressful situation (D’Zurilla & Goldfried, 1971; Eskin, 2013; Nezu et al., 2013). During social problem solving, the individual actively attempts to find effective responses to stressful tasks encountered in daily life (D’Zurilla & Nezu, 2007). Therefore, this process serves as a coping resource (Eskin et al., 2012).

Problem-solving studies have been around since the beginning of the twentieth century (Dominowski & Bourn, 1994). However, the contemporary problem-solving model originates from D’Zurilla and Goldfried’s influential article published in 1971, “Problem-Solving and Behavior Modification.” While prior studies focused on artificial problems in laboratory settings and only *described* how problem solving works, these

authors focused on real-life problem solving and *prescribed* problem solving as it occurs effectively in real-life settings (Morera et al., 2006). To emphasize that problem solving occurs in the real-life “social” environment, the revised model was referred to as social problem solving (D’Zurilla & Nezu, 1982). The adjective “social” is not meant to limit the process to a specific kind of problem (D’Zurilla & Nezu, 1990).

The social problem-solving model takes inspiration from various fields and theories. In the late twentieth century, Bandura proposed a relationship between self-efficacy and coping efforts (Bandura, 1977a). The concept of self-efficacy consists of efficacy expectations and outcome expectations. While efficacy expectations reflect the individual’s assumptions regarding their ability to manipulate their behavior effectively, outcome expectations indicate the assumptions regarding the consequences of their behavior (Bandura, 1977b). These concepts were found to be significant predictors of performance during stressful tasks. Eventually, to lay a foundation for the evaluation of social problem-solving performance, Nezu (2004) and colleagues (D’Zurilla & Nezu, 2007) adapted these terms to the social problem-solving theory.

Lazarus’ relational model of stress also contributed to the current model of social problem solving. Initially, Lazarus (1963) proposed a model suggesting that stress requires an interpretation by the individual who perceives the situation. In other words, stress is neither caused by the environment nor the person, but rather a combination of both. Following this, Lazarus and Folkman (1984) explained how stress responses are powered by the evaluations made during a process named cognitive appraisal. These evaluations involved the quality of the situation, as well as the individual resources and coping options. With another revision based on these theories, social problem-solving theory emphasized the way the problem-solver perceives the issues, thereby making the framework more versatile and comprehensive. It is highlighted in the social problem-solving theory that negative appraisals trigger stress responses, while positive appraisals are associated with minimized stress and motivation to approach the problem (D’Zurilla & Nezu, 2007). The focus on perception is one of the factors that make social problem solving idiographic. Each step of the social problem-solving process is unique to the individual and the circumstances of the problematic situation (Nezu et al., 2013; Eskin, 2013). One solution that is effective for one person and issue may not be as effective for another. In addition, social problem-solving theory approaches emotion in a more structured way than Lazarus’ framework. While Lazarus and Folkman (1984) suggested

that it is not proper to use problem-solving strategies to reach emotion-focused goals, contemporary social problem-solving strategies are also effective in altering the emotional responses to problematic situations. This current model of social problem solving has three major concepts: problem, solution, and problem solving (D’Zurilla et al, 2004a).

According to Lazarus (1963), humans are active organisms that engage with their environment. Therefore, the situation is appraised as a problem only when it requires coping resources beyond what the individual possesses (Lazarus & Folkman, 1984). Based on this premise, the contemporary social problem-solving theory suggests that “a problem is not a product of either the environment or the person alone” (Nezu et al., 2015, p. 161). Only when the situation comes up with a demand and involves obstacles that inhibit the availability of effective responses, is it perceived as a problem (D’Zurilla et al., 2004a; Nezu et al., 2013). The demands in a problematic situation may arise from the environment, within the individual, or between individuals (D’Zurilla et al., 2004a). The obstacles, however, are barriers that prevent the problem-solver from responding effectively. The problem-solver might encounter a variety of obstacles, such as ambiguity or lack of resources (Nezu et al., 2015).

The problematic situation can vary in quality. Either present or anticipated, the problem may consist of a single event, a series of events, or a chronic situation (D’Zurilla et al., 2004a; D’Zurilla & Nezu, 2007). Furthermore, the nature of the problems may also vary, encompassing personal, interpersonal, impersonal, or social issues (Eskin, 2013). Because problems demand adaptive responses, people who are highly efficient in problem solving can generally apply such skills across diverse problems (Nezu, 2004). However, individuals may not be as competent across all types of issues (Nezu et al., 2013).

A solution is the product of the social problem-solving process applied to a specific problem (Nezu et al., 2013). The individual may aim to change the problematic situation, their negative reactions to the problem, or both (Nezu, 2004). Just as social problem solving is, these coping responses are also idiographic. Therefore, the question of whether a solution is effective or not depends on the problem-solver and the environment.

An effective solution is the solution alternative that (1) achieves the problem-solving goal, (2) maximizes positive consequences, and (3) minimizes negative consequences (D’Zurilla et al., 2004a). The consequences of the implemented solution

can have an impact on the self or the others, including “significant others who are responsible for judging the problem-solver’s coping responses” (D’Zurilla & Nezu, 1987, p. 466). In addition, the solution can have a long-term or short-term influence. In the social problem-solving process, the problem-solver should consider these consequences and evaluate the process based on social norms, personal values, and goals (Nezu et al., 2015).

Social problem solving refers to the active process by which individuals attempt to identify adaptive coping responses to demands in real-life situations (D’Zurilla et al., 2004b; Nezu et al., 2013). Social problem solving is significantly effective because it makes a variety of alternative solutions available (D’Zurilla & Goldfried, 1971). The increase in quantity assists the problem-solver in selecting the most effective solution alternative (Nezu & D’Zurilla, 1981). When performed effectively, social problem solving can reduce distress and negative affect. In a study exploring the relationship between social problem solving and distress, Nezu (2004) has indicated that continued ineffective attempts to solve problems result in (1) reduced motivation, (2) decreased problem-solving performance, and (3) increased probability of experiencing negative affect. If problem-solving attempts are consecutively unsuccessful, problems increase in number or severity, thus creating a vicious cycle of negative outcomes. This cycle starts with problems and is followed by negative cognitive, behavioral, and emotional reactions. In the end, unsuccessful attempts raise additional problems, transforming the stressful situation into a distressful one (Nezu et al., 2015).

Efficient social problem solving is known for contributing to psychological well-being and social competence (Nezu, 2004). In addition, it serves as a protective factor against psychological distress in many populations (Abdollahi et al., 2014; LeBlanc et al., 2011; Quomma & Greenberg, 1994). Hence, social problem-solving interventions have been used as a transdiagnostic prevention strategy across various populations (Dozois et al., 2009). Various studies on prevention and treatment processes indicate that effective social problem solving is associated with psychological well-being. When individuals learn to solve problems effectively, their levels of psychopathology tend to decrease. Additionally, a deficiency in social problem-solving skills increases the likelihood of experiencing psychopathological symptoms (Nezu, 2004). This notion has been tested across a variety of populations. For instance, Heapy and colleagues (2024) reported that social problem solving was associated with suicidality. Additionally, Belzer et al. (2002)

concluded that poor problem-solving skills are associated with worry and anxiety in college students. Studies carried out in Türkiye reported similar associations. Turgut (2021) found out that after problem-solving therapy interventions, suicide risk decreased in patients who had previously attempted suicide. Similarly, Demirbağ (2013) reported in an experiment that providing problem solving psychoeducation significantly decreased anxiety and depression. In addition, Kardaş et al. (2023) administered a study to see the effects of problem solving therapy on adolescents diagnosed with alcohol and substance use disorder. Their analyses showed that anxiety and depression points were significantly decreased in the experiment group while the motivation for treatment increased. Eskin et al. (2012) also reported that social problem solving training decreases perceived stress while improving self-esteem. Similarly, social problem-solving therapy was found to reduce psychopathological symptoms such as somatization, obsessive-compulsive disorder symptoms, depression, and anxiety (Engin et al., 2023).

D’Zurilla and Nezu (1990) developed a measure named the Social Problem-Solving Inventory (SPSI) to observe social problem solving. This instrument consisted of two major components: problem orientation and problem-solving proper. However, Maydeu-Olivares and D’Zurilla (1995, 1996) reported that the model did not fit the data generated by SPSI and demonstrated a five-factor structure instead. The five-dimensional model forms the contemporary social problem-solving model that we use today, consisting of two general, partially independent processes: problem orientation and problem-solving style (Nezu, 2004). While problem orientation consists of two cognitive-emotional schemas, the problem-solving style includes three cognitive-behavioral processes.

1.1.1 Problem Orientation

Problem orientation is a general set of cognitive-affective schemas (Nezu et al., 2015). It is associated with the problem-solver’s beliefs, attitudes, and emotional reactions to problems and one’s ability to cope with problems effectively. In simpler terms, problem orientation implies the way one perceives problems and how this perception affects their emotions (Eskin, 2013). The problem-solver carries out five evaluations within the scope of problem orientation: (1) problem recognition (i.e., recognizing the problem rather than ignoring or avoiding it), (2) problem attribution (i.e.,

causal beliefs regarding the nature of problems), (3) problem appraisal (i.e., assessment of the problem and its demands), (4) perceived control (i.e., beliefs regarding that problems are solvable and one is capable of solving it), and (5) time/effort commitment (i.e., estimating the required time/effort the problem demands, and being willing to commit to solving it) (D’Zurilla & Nezu, 2007). These evaluations either encourage the individual to take action against the problem, or discourage them from doing so. Therefore, it has also been defined as a metacognitive process that serves a motivational function (D’Zurilla et al., 2004a).

Two tendencies function independently from each other: positive and negative problem orientation (Nezu, 2004). Positive problem orientation (PPO) is an adaptive mindset characterized by the tendency to perceive problems as solvable and perceive oneself as capable of solving problems (Eskin & Aycan, 2009; Morera et al., 2006). A problem-solver who adopts a PPO is more likely to perceive problems as challenges rather than threats and have self-efficacy regarding their ability to cope with problems effectively (Nezu et al., 2015). PPO is associated with the belief that one can solve problems and implement solutions (D’Zurilla & Nezu, 2007). This mindset motivates the problem-solver to initiate coping behavior and promotes persistence and tolerance (Nezu et al., 2015). A positively oriented problem-solver is more likely to approach problems and persist until they can manage the task effectively.

In contrast, negative problem orientation (NPO) refers to the tendency (1) to view problems as major threats to well-being, (2) to expect them to be unsolvable, (3) to become frustrated easily when confronted with them, and (4) to doubt one’s ability to cope effectively (Nezu, 2004). This dimension of problem orientation is associated with negative emotions and avoidance tendencies (Nezu et al., 2015). In other words, an individual who adopts NPO is more likely to worry destructively and less likely to make an effort to solve the problem. Indeed, NPO has been associated with pessimism and depression (Nezu, 2004).

1.1.2 Problem-Solving Style

Problem-solving style refers to the cluster of cognitive and behavioral attempts to find an effective solution to the problem (D’Zurilla & Nezu, 2007; D’Zurilla et al., 2004a). The style problem-solvers tend to adopt implies the way they comprehend the

situation and the attempts they make to cope with the task (Nezu et al., 2015). Problem-solvers can be addressed in three tendencies: (1) rational problem-solving style, (2) impulsive/careless problem-solving style, and (3) avoidant problem-solving style. Rational problem-solving style (RPS) is defined as the constructive cognitive-behavioral dimension of social problem solving. Problem-solvers who adopt RPS tend to respond to problematic situations in an active, planful, and deliberate way (D’Zurilla & Nezu, 2007). Accordingly, RPS consists of four major skills: (1) defining and formulating the problem, (2) generating a variety of response alternatives, (3) decision making, and (4) solution implementation and verification (Nezu et al., 2013).

Impulsivity/careless problem-solving style (IPS) and avoidant problem-solving style (APS) are considered as maladaptive or dysfunctional problem-solving styles. Just like RPS, IPS is characterized by active attempts to solve problems. However, these attempts are hurried, impulsive, and careless (Nezu et al., 2015). Likewise, the individual scans solution alternatives and potential outcomes in an unsystematic manner (Morera et al., 2006). As a result, the problem is more likely to persist, and new problems are more likely to emerge (Eskin, 2013). Lastly, APS is distinguished by passivity and procrastination (Nezu, 2004). Problem-solvers who adopt this approach tend to avoid problems, put off solving them, wait for problems to solve themselves, and depend on others to solve their own problems.

In summary, NPO, IPS, and APS are considered as the components of maladaptive social problem solving. Research suggests that outcomes of solution implementation are predicted by problem orientation and problem-solving styles (D’Zurilla & Nezu, 2007). This relationship suggests that maladaptive problem-solving processes might produce unwanted results. Indeed, these components are associated with poor self-esteem, suicidal risk, hopelessness, distress, and psychological maladjustment (D’Zurilla & Nezu, 2007; Nezu et al., 2015). Additionally, in the relationship between stress and distress, social problem solving was reported as an important mediator (Chang, 2002; Eşigül & Cenkseven-Önder, 2017; Yavuzer et al., 2017) and moderator (Nezu, 1986; Esposito & Clum, 2002; Goodman et al., 1995; Atik-Bilgenöglü, 2009). In other words, social problem solving explains the mechanism, strength, and direction of the relationship between stress and distress.

1.2 Eating Pathology

To understand eating pathology, defining normal eating behaviors is important. There are multiple systems that regulate our food intake and energy expenditure. These systems ensure our biological survival, process information, and produce various outputs that shape our behavior (Berthoud & Morrison, 2008). Treasure et al. (2010) classify these regulatory systems into three components: homeostatic system, drive system, and self-regulation system. While the homeostatic system initiates the subjective states of hunger and satiety, the drive system distributes information from sense organs. Through these systems, the reward value of food is associated with the drive to seek food and eat. Finally, the self-regulation system “contextualizes appetite within life goals, values, and meaning” (p. 585). In other words, eating and eating-related behavior acquire another level of personal and societal meaning. For instance, diet culture is a phenomenon that attaches moral values to eating and eating-related behaviors (Morris, 2020). It is not perceived as moral to consume “unhealthy” foods, as it is an indication of weak willpower. The influence of diet culture on eating pathology has been mentioned in various research. For instance, a recent study on disordered eating indicated that exposure to diet culture is associated with qualifying for a referral to an eating disorder professional (Vanderlinde-Padgett, 2024). This means that sociocultural factors also have an impact on eating attitudes.

Various factors on the individual level have also attracted researchers’ attention. For instance, disordered eating behaviors are risk factors for developing eating pathology (Stice et al., 2008). Additionally, certain parental attitudes, such as restriction of food intake, may increase the child’s concern about food (Fisher et al., 2009), precipitating eating pathology. Body dissatisfaction (Ferreiro et al., 2011) and depression-related symptoms (Goldschmidt et al., 2015) were also reported to be significant predictors of disordered eating. In addition to these psychological and social factors, biological risk factors also play a significant role in the development of eating pathology. Treasure and colleagues (2010) propose that disturbances in energy regulatory systems might be strongly associated with abnormal eating behaviors (i.e., non-normative behaviors in the field of eating and related areas). For instance, eating disorders were found to be associated with differences in neural activity in the limbic system, which is one of the brain regions that link food, reward, and emotions with real-life contexts (Wonderlich et

al., 2021). Similarly, Friederich et al. (2013) reported that eating disorder patients demonstrated an excess activity in their emotional and fear networks related to food.

Considering the literature on the relationship between emotions and eating, exploring how adaptive eating behavior can occur without serving as an emotional response or a coping strategy is crucial. Researchers have proposed intuitive eating, which is defined as humans' innate skills to regulate their energy intake (Tribble & Resch, 1995; as cited in Tylka, 2006). The term is inclusive of four dimensions: (1) unconditional permission to eat, (2) eating for physical rather than emotional reasons, (3) reliance on hunger and satiety cues, and (4) body-food choice congruence (Tylka & Kroon Van Diest, 2013; Barrada et al., 2018). Therefore, an intuitive eater would follow their physical hunger cues to eat whenever they are hungry. Focusing on satiety cues, they would eat the food that is desired. The physical cues would help the intuitive eater to determine how much to eat. Being aware of internal signals is essential to intuitive eating, as it helps the intuitive eater initiate and conclude eating. However, it is important to note that an intuitive eater would follow physical internal signals rather than emotional ones.

On a continuum with eating disorders, Tylka and Wilcox (2006) have suggested intuitive eating to be the exact opposite of an eating disorder. Eating disorders are more structured by definition and more severe than eating pathology. As significant threats to psychological and physiological health, eating disorders remain poorly understood, as indicated by the high prevalence of the residual diagnostic category (Fairburn & Bohn, 2005). Understanding the underlying mechanisms, such as risk and maintenance factors, etiology, and prognosis, is crucial for developing effective treatments and interventions for eating disorders (Insel et al., 2010).

1.2.1 Eating Disorders

Eating disorders are characterized by disturbances in eating and eating-related behavior, sometimes resulting in the alteration of consumption and absorption of food (Cooper & Murphy, 2021). Treasure and colleagues (2010) discuss three categories of common eating disorder symptoms: behavioral symptoms, psychopathology, and physical symptoms. Common behavioral symptoms of eating disorders include but are not limited to, restrictive behavior regarding food and eating (e.g., prolonged fasting), binge eating (i.e., consuming excessive amounts of food in a limited time, accompanied

by a feeling of loss of control), body checking (e.g., repeatedly checking body weight and shape), and purgative behavior (e.g., self-induced vomiting). Regarding their psychopathology, individuals with eating disorders demonstrate body image disturbance (e.g., intense fear of weight gain, glorifying body weight and shape while determining their self-worth). This dysfunctional system of psychopathology maintains disordered eating behaviors (e.g., smoking as a weight-control method, Maldonado-Molina et al., 2007), which in turn generates the physical symptoms of eating disorders. In other words, physical symptoms are biological indicators of the maintained disordered behaviors (e.g., weight loss, fatigue, lower sex drive, amenorrhea).

Eating disorders emerged much earlier than most people estimate. In the medical literature, the first case of an eating disorder was introduced by Morton (1714): a young female reporting symptoms of inanition and amenorrhea in 1694 (as cited in Yates, 1990). Besides the medical literature, there are a lot of cases resembling eating disorders throughout history, going as far back as the ninth century (Habermas, 1986). In today's clinical practice and research, we have operational definitions of what an eating disorder is: a disturbance that involves altered eating behaviors (e.g., food consumption) and preoccupation with food, body weight, and shape (American Psychiatric Association, 2013; World Health Organization, 2021). Due to its nature as a disorder, eating disorders also impair the individual's physiological health or psychosocial functioning (American Psychiatric Association, 2013). Eating disorders are known for being difficult to treat once established (Cooper & Del Grave, 2017). Furthermore, there is an unmet need for appropriate treatment, as most patients with eating disorders seek treatment for weight loss (Hart et al., 2011). Both community members and medical professionals require support in the recognition and treatment of eating disorders.

According to the current *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-5-TR; American Psychiatric Association, 2022), there are three main eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder.

Anorexia Nervosa

By definition, anorexia nervosa is associated with restriction of food consumption in the context of a disturbance in the body perception and an intense fear of gaining weight (Black & Andreasen, 2014). This restriction of food intake is severe and selective (Cooper & Murphy, 2021). Individuals diagnosed with anorexia nervosa tend to avoid food they perceive as fattening. Clinical presentation of anorexia nervosa also includes engaging in

self-destructive behaviors to lose weight (Shatkin, 2009). Some examples are extreme forms of weight control, such as driven types of exercising and self-induced vomiting. Therefore, decreased energy intake is not the only feature associated with eventuated low body weight, as self-destructive behaviors influence energy regulatory systems.

Despite being specific, diagnostic criteria for anorexia nervosa do not define a homogeneous group. Clinicians are expected to specify if the disorder is the restricting type or the binge-eating/purging type. In addition, Bhattacharya et al. (2020) emphasize the common occurrence of atypical anorexia: individuals with the same clinical presentation lose a significant amount of weight while remaining within a normal body weight range.

There are multiple theories discussing how anorexia nervosa develops and is maintained. First, Fairburn (2008) proposes that a component called “over-evaluation of shape and weight and their control” is present in eating disorders (p. 12). This component can be defined as a dysfunctional system of self-evaluation. It limits a person's life to focusing solely on shape, weight, and the ability to control them (Cooper & Murphy, 2021). Furthermore, Garner (1993) explained predispositions to anorexia nervosa in individuals (e.g., psychological factors such as cognitive deficits, psychological trauma such as childhood sexual abuse), familial (e.g., specific patterns of interaction within the family such as overprotectiveness of the parents), and cultural (e.g., pressures on women to diet) levels. The author mentions inadequate coping skills as a precipitating factor, which aligns with many other researchers' views. For instance, Weerasekera (2009) emphasizes coping-response styles within the context of predisposing, precipitating, perpetuating, and protective factors associated with anorexia nervosa. In the face of adverse events, the inability to effectively deal with issues might emerge in the clinical picture of anorexia nervosa. Many additional studies indicate that anorexia nervosa is associated with lower coping scores (Oldershaw et al., 2015; Villa et al., 2009; Soukup et al., 1990).

Bulimia Nervosa

Bulimia nervosa is defined by recurrent episodes of binge eating and inappropriate compensatory behaviors (Wolever & Best, 2009). Binge eating episodes are characterized by consuming large amounts of food within a discrete period, accompanied by a sense of loss of control or overeating (American Psychiatric Association, 2013). While binges provide a brief period of relief, they are usually followed by feelings of disgust and guilt

(Shatkin, 2009). In the context of bulimia nervosa, self-evaluation depends heavily on body shape and weight, indicating that over-evaluation is present in the clinical table. Consuming excessive amounts of food triggers aversive emotions and threatens one's self-worth. As a result, individuals might engage in compensatory behaviors (e.g., vigorous exercise, purging such as self-induced vomiting) to prevent weight gain (Black & Andreasen, 2014). A vicious cycle of binges and compensatory behaviors emerges.

In bulimia nervosa, every clinical feature is hypothesized to emerge from over-evaluation of shape and weight and their control, except for binge eating. Fairburn (2008) interprets binge eating because of dietary restrictions. Several other studies have reported similar findings (e.g., Zunker et al., 2011). Rather than adopting general guidelines regarding their eating, people with bulimia nervosa adopt rigid restrictions that are usually not applicable. These rules are so rigid that it is almost impossible not to break them. In addition, even a minor dietary slip can lead a person to accuse themselves of lacking self-control. Breaking their own rules is so catastrophic for the individual that they abandon all dietary restraint and engage in a binge (i.e., overeating accompanied by a feeling of loss of control). In the literature, the influence of perfectionism in this process is also discussed (Sherry & Hall, 2009), which might explain why minor slips can trigger extreme reactions.

Fairburn (2008) depicts dietary restriction as a “non-compensatory weight-control behavior” (p. 19) and “a routine form of weight control” (p. 14), suggesting that it is initiated without any link to the occurrence of binge eating. One instance of compensatory behavior is purging, which is defined as an attempt to get rid of the consumed food. Fairburn describes purging as a collective noun for misuse of laxatives or diuretics and self-induced vomiting. In 2003, Jeppson and colleagues conducted a qualitative study interviewing individuals diagnosed with bulimia nervosa and reported that participants view purging as a means of an attempt to control the situation, improve social and self-regard, and regulate and cope with emotions. Additionally, Shatkin (2009) proposes that individuals with bulimia nervosa “turn to food in order to cope” (p. 251).

Another perspective on bulimia nervosa is one that emphasizes negative reinforcement. Slade (1982) discusses how people with bulimia nervosa avoid the problems they experience, just like they avoid weight gain. Like anorexia nervosa, preoccupation with body weight and shape in bulimia nervosa may serve as a buffer between the problems and the problem-solver. In addition, binge episodes may serve as

a distraction from the negative mood that arises after dietary slips. Purging may also act to compensate for the feelings of shame and guilt created by binge episodes.

Binge Eating Disorder

Saguy and Gruys (2010) refer to anorexia and bulimia nervosa as “thinness-oriented eating disorders” (p. 234). However, binge eating disorder is not, by definition, associated with the pursuit of thinness. It is characterized by recurrent binge episodes, without subsequent compensatory behaviors (Cooper & Murphy, 2021). Contrary to common belief, binge eating disorder can be seen across all individuals within any weight range. It is proposed that by the time patients seek treatment, they are more likely to be obese or overweight. Even though the disorder is often associated with obesity (Bhattacharya et al., 2020), studies indicate that only a minority of binge eating disorder patients meet the criteria for obesity (Fairburn et al., 2000).

With respect to the binge eating disorder’s similarity with bulimia nervosa, Black and Andreasen (2014) proposed that the two disorders represent different stages of the same underlying disorder. Binge eating disorder involves little or no extreme weight control behaviors such as purging (Fairburn et al., 2000). Compared to bulimia nervosa, binge eating disorder is associated with lower eating disorder psychopathology and symptoms. The transdiagnostic component within eating disorders, over-evaluation of shape and weight and their control, may not be present in individuals with binge eating disorders. In their study with binge eating disorder patients, Grilo et al. (2013) reported that only 58% of the participants demonstrated over-evaluation. While researchers recommend that over-evaluation should be taken into consideration as an indicator of functional impairment (Coffino et al., 2019), the absence of over-evaluation in cases of eating disorders initiates a discussion: eating pathology can occur without an underlying preoccupation about body weight and shape.

Eating Disorder Not Otherwise Specified

Eating disorders not otherwise specified (EDNOS) are the residual category of DSM’s eating disorder diagnostic criteria (Thomas et al., 2009). The cases that fall into EDNOS are clinical cases that do not fall into clearly defined symptom sets we know as eating disorders. EDNOS is not different from formally recognized eating disorders in terms of eating pathology, general psychopathology, or physical health. Although it is the most prevalent category of eating disorders, EDNOS tends to be neglected by researchers (Fairburn & Bohn, 2005). Fairburn and colleagues (2007) have reported that 60% of the

patients in an eating disorder clinic are diagnosed with EDNOS. Another study by Machado et al. (2007) reported that 77.4% of eating disorder patients were diagnosed with EDNOS. The authors concluded that in a nationwide community sample, the prevalence of EDNOS was 2.37%, while both prevalence rates for anorexia and bulimia nervosa were below 0.40%. In conclusion, EDNOS is the most common eating disorder both in inpatient and outpatient settings, and the high prevalence rates of this residual category reveal the shortcomings of the diagnostic system.

Just as other eating disorder categories (Luo et al., 2016), EDNOS is described as significantly heterogeneous. Fairburn and Bohn (2005) have explained EDNOS in two subgroups: (1) clinically impairing eating disorders that are uncharacteristic of anorexia nervosa, bulimia nervosa, or binge eating disorder and (2) sub-threshold variants of anorexia nervosa, bulimia nervosa, or binge eating disorder. The authors have also declared that important etiologic and maintenance processes are excluded from eating disorders' diagnostic process. Similarly, Vitousek and Manke (1994) point out that “the stereotyped views of anorexic and bulimic personality are oversimplifications of a complex clinical reality” (p. 137). In addition, despite the common stereotype that eating disorders are associated with extreme underweight or overweight, most individuals diagnosed with eating disorders have a body weight within the normal range (Fairburn, 2008). The heterogeneity of diagnostic groups and the high prevalence rate of EDNOS suggest that a common understanding of eating disorders has yet to be established. What we know as eating disorders are oversimplified and premature schemas that cast out the majority of clinical cases. Therefore, this study proposes examining eating pathology as a continuous phenomenon that encompasses both clinical and non-clinical cases.

1.2.2 The Definition of Eating Pathology and Why We Study It

Eating pathology can be defined as abnormal eating behaviors included in the symptom sets of various eating disorders. The term encompasses a broader range of maladaptive eating behaviors and attitudes that do not meet the diagnostic criteria for eating disorders. In the context of this study, there are several advantages to focusing on eating pathology and not examining specific eating disorder diagnostic groups: (1) eating disorder diagnoses have limited utility, (2) eating pathology is common in non-clinical

samples, (3) it is more convenient to research eating pathology as a continuous construct instead of categorizing individuals into diagnoses.

Limited Utility of Eating Disorders

Cooper and Murphy (2021) discuss how most eating disorder patients migrate across the diagnoses. The authors propose that this migration is not random, and it reflects a pattern: eating disorders start with dietary restriction and proceed with loss of control over overeating and episodes of binge eating. In support of this notion, Fairburn and Bohn (2005) state that cross-diagnostic similarities between eating disorder diagnoses are even more apparent when a longitudinal perspective is adopted. Furthermore, it has been argued that there is only one eating disorder, and the criteria in major diagnostic systems represent different stages of a single disorder (Luo et al., 2016; Wildes & Marcus, 2013). Similarly, Fairburn and Cooper (2011) suggest that eating disorder diagnoses only represent *snapshots* during a single eating disorder.

The approach to eating disorder criteria while developing the next DSM after DSM-IV, researchers aimed to reduce the need for the EDNOS category (Call et al., 2013). In DSM-5 (American Psychiatric Association, 2013), anorexia nervosa and bulimia nervosa criteria were revised to be less strict, and an additional diagnostic criterion for binge eating disorder was presented. The objective was to reclassify the cases in the residual category. However, Fairburn et al. (2007) suggested years ago that these attempts wouldn't be successful, as binge eating disorder cases were not common enough to make a significant change. Their comparison between the relaxed and regular diagnostic criteria for anorexia nervosa and bulimia nervosa did not have much effect. Fairburn and Cooper (2011) also argued that these proposed changes to DSM-5 are not sufficient to overcome the manual's shortcomings. Even though Smink et al. (2013) reported that the frequency of EDNOS is reduced when the current DSM-5 criteria are applied to samples, EDNOS is still the most prevalent eating disorder (Alfalahi et al., 2022). Additionally, the course and outcome of anorexia and bulimia nervosa do not showcase any differences between the clinical presentation of DSM-IV and DSM-5. In conclusion, most eating disorder criteria reflect heterogeneous categories with little clinical utility (Cooper & Dalle Grave, 2017). It is evident that the diagnostic criteria for eating disorders are still inadequate, and etiology and maintenance processes are not well comprehended.

Eating Pathology is Common in Non-Clinical Samples

Research indicates that eating pathology is more prevalent than formally diagnosed eating disorders. In other words, many individuals experience disordered eating behaviors without qualifying for a diagnosis (Luo et al., 2016). For instance, 12% of a community sample reported engaging in binge episodes (Thompson & Bardone-Cone, 2019). Even if the existence of eating pathology behaviors does not necessarily indicate a diagnosis of a mental disorder, it is of significant importance (Pereira & Alvarenga, 2007). Therefore, this study aims to observe eating behaviors beyond the barriers of eating disorders. Understanding eating pathology's underlying mechanisms (e.g., risk and maintenance factors, etiology, prognosis) is crucial in developing treatments and interventions for eating disorders (Insel et al., 2010; Kirmayer & Crafa, 2014).

Eating Pathology is Convenient to Study

Studying with a community sample is more accessible than working with clinical samples. Using a clinical group would reduce the sample size and decrease the generalizability of the results. Additionally, new confounding variables could emerge because it would be challenging to control the treatments the clinical sample is receiving. In conclusion, studying clinically significant abnormal eating behaviors without limiting diagnostic symptom sets allows us to explore shared mechanisms and subclinical cases of eating disorders while avoiding diagnostic overlaps. It also provides a more convenient measurement and analysis.

1.3 *Eating Pathology and Social Problem-Solving Skills*

Research consistently suggests that altering energy intake might function as an attempt to cope (Spoor et al., 2006; Fairburn et al., 2003). And as previously discussed, social problem solving is significantly associated with numerous psychopathologies (Eskin, 2013; Nezu, 2004). Furthermore, various theories on the etiology and maintenance of eating disorders also highlight deficiencies in coping and social problem solving. Below, the relationship between social problem-solving theory and eating pathology is discussed in detail. Because research on the relationship between eating pathology and social problem solving are scarce, I supported my arguments by literature on eating disorders and coping skills.

Fairburn (2008) has suggested a transdiagnostic model of eating disorders. This model was developed from the perspective of traditional cognitive behavior therapy, aiming to improving the quality of life by reducing the symptoms of eating disorders (Dudek et al., 2014). Additionally, a new transdiagnostic therapy protocol was developed for eating disorders based on this model: cognitive behavioral therapy-enhanced (CBT-E). Evidence for the efficacy of CBT-E has been provided by many reviews (Dahlenburg et al., 2019; Atwood & Friedman, 2019; Linardon et al., 2017). Considering the significance of the transdiagnostic model of eating disorders and CBT-E, I presented a summary of the model and discussed social problem solving in the light of its theory.

Fairburn's (2008) transdiagnostic model of eating disorders starts with the core psychopathology: over-evaluation of shape and weight and their control. This term refers to judging one's self-worth in terms of their shape, weight, and their ability to control them. This tendency is different from "normative discontent" (p. 12) seen in the general population, as over-evaluation is exclusive to eating disorders. Over-evaluation is linked to non-compensatory weight and shape control behaviors (e.g., strict dieting), which leads to either binge eating or significantly low body weight. The author proposed that binge eating is predicted by life events and mood change and that it leads to compensatory weight and shape control behaviors such as self-induced vomiting. Additionally, low body weight is suggested to predict binge eating. The model can be found in Figure 1.1.

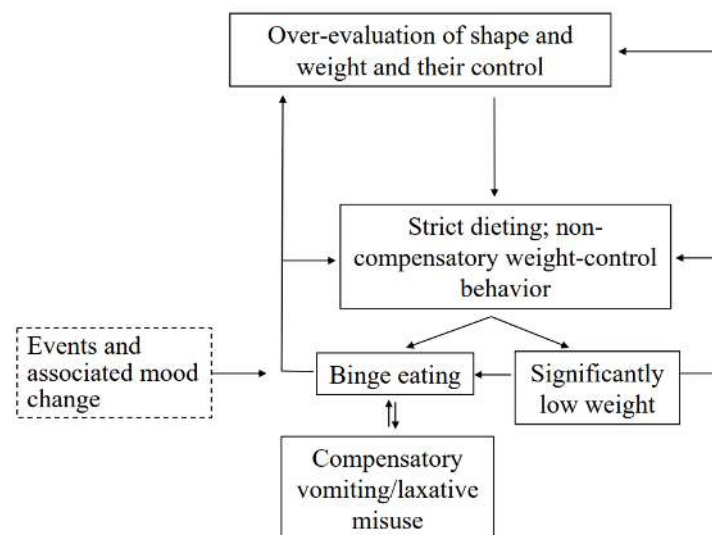


Figure 1.1: Transdiagnostic model of eating disorders.

Note. Reproduced from *Cognitive Behavior Therapy and Eating Disorders* by Christopher G. Fairburn. © 2008 by The Guilford Press.

The mentioned model has several limitations. For instance, it does not specify when non-compensatory behaviors lead to either binge eating or low body weight. What exactly determines who demonstrates the clinical presentation of which eating disorder? Additionally, the mechanisms underlying the relationships between components are unclear. One behavior might not always lead to the other. Here, I drew conclusions from the conceptualizations of anorexia nervosa and bulimia nervosa. Slade (1982) and Shatkin (2009) emphasized the role of avoidance in maintaining the preoccupation with eating and body weight and shape. On the other hand, Lavender and Mitchell (2015) argued that research on impulsivity and eating disorders were mostly focused on binge eating and purging tendencies. In conclusion, APS and IPS might help explain some of the variance in these links. For individuals with higher APS, over-evaluation could result in stricter non-compensatory weight and shape control behaviors, and in turn, lower body weight. This mechanism might serve as a way to avoid negative affect. For individuals with higher IPS, strict dieting and negative events could create a tendency to binge, because food could easily improve negative affect (Allen, 2012/2021). Consequently, individuals with higher IPS could be inclined to purge, especially while dealing with the negative affect that emerges after bingeing, such as shame. In conclusion, social problem-solving perspective might improve our understanding of eating disorders. The following section examines the specific relationships between eating disorder diagnoses and social problem solving.

1.3.1 Bulimia Nervosa and Social Problem-Solving Skills

Individuals with bulimia nervosa use strict dieting as a weight control behavior (Fairburn et al., 2003). Even minor dietary slips are perceived as a lack of self-control, resulting in a short-term termination of dietary restriction (i.e., binge eating). When attempts to restrict eating are repeatedly disrupted by binge episodes, concerns about weight, body shape, and control tend to increase. As a result, dietary restriction is also intensified. According to the theory of social problem solving, psychopathology occurs when attempts to solve problems are repeatedly unsuccessful (Nezu, 2004). If we approach an excessively strict diet as a potential solution, one could argue that if it triggers recurrent binges, the individual could perceive the situation as a failed problem-solving attempt. From the social problem-solving perspective, this cycle might increase the

probability of triggering a state of eating pathology. Additionally, bulimia nervosa is associated with the belief that one will not be able to cope with adverse feelings and thoughts (Fairburn et al., 2003). NPO, which is also a risk factor for psychopathology (Nezu et al., 2008), is associated with the same belief by definition. That is to say, social problem-solving theory may account for the clinical presentation of bulimia nervosa.

Likewise, social problem-solving theory might also contribute to explaining the maintenance of bulimia nervosa. Fairburn et al. (2003) proposed four mechanisms that maintain bulimia nervosa: (1) clinical perfectionism, (2) core low self-esteem, (3) mood intolerance, and (4) interpersonal difficulties. As a dysfunctional system for self-evaluation, clinical perfectionism perpetuates the symptoms of the disorder. Core low self-esteem is a pervasive negative view of self, which is experienced as a permanent part of identity. Both mechanisms are theoretically associated with inefficient problem solving (Flett et al., 1996; Hamarta, 2009). Additionally, Fairburn and colleagues (2003) defined mood intolerance as the inability to cope efficiently with emotional states. Binge eating and other disordered eating behaviors were accordingly mentioned as “dysfunctional mood modulatory behaviors” (p. 517). In support of this, Spoor and colleagues (2006) proposed that eating can be utilized as a coping strategy against negative affect for both clinical and non-clinical groups. All these findings indicate that disordered eating behaviors in the diagnostic category of bulimia nervosa are significantly associated with inefficient social problem solving. Specifically, these maintenance factors are closely related to NPO in several ways. Individuals with mood intolerance and low self-esteem often believe they are unable to cope with problematic situations, much like problem-solvers characterized by an NPO. Both mood intolerance and NPO are associated with a low tolerance for frustration. There seems to be an overlap between these processes, making it more likely to observe a significant relationship between problem solving and bulimia nervosa.

1.3.2 Anorexia Nervosa and Social Problem-Solving Skills

Anorexia nervosa and bulimia nervosa have similar maintenance mechanisms. These commonalities become even more evident when adopting a longitudinal perspective (Fairburn et al., 2003). Clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties also operate in anorexia nervosa, indicating that

social problem solving might again explain the onset or the maintenance of the symptoms. Moving on to other discussions on the nature of anorexia nervosa, Shatkin (2009) stated that individuals with anorexia nervosa “turn away from food in order to cope” (p. 251). Additionally, Slade (1982) interpreted preoccupation with food and eating of anorexia nervosa as “a form of avoidance behavior” that allows individuals to “avoid direct confrontation with aversive stimuli” (p. 173). Slade’s suggestion of avoidance as a significant maintenance factor implies a potential association between APS and eating pathology. APS is defined as avoiding to approach a problem directly, ignoring a problematic situation, and taking care of a problematic matter. This process acts as negative reinforcement, which strengthens the symptoms of the disorder (e.g., dietary restriction) while decreasing exposure to adverse emotions and events. Studies on the relationship between social problem solving and eating pathology support this assumption. Paterson and colleagues (2011) compared individuals with anorexia nervosa to healthy controls and found significant differences in PPO, NPO, IPS, and APS. Anorexia nervosa was associated with lower scores on PPO and higher scores on NPO, APS, and IPS. Similarly, Swanson et al. (2010) reported significantly higher scores of NPO and APS in individuals with anorexia nervosa. In conclusion, if the preoccupation with eating and body weight and shape is considered an APS strategy, it might allow individuals to avoid confronting real-life issues and procrastinate dealing with them.

1.3.3 Binge Eating Disorder and Social Problem-Solving Skills

Research suggests that binge eating disorder is associated with maladaptive coping, as well (Dingemans et al., 2007). Binge eating episodes occur in response to negative moods in an attempt to regulate the effects (Hilbert & Tuschen-Caffier, 2007). Furthermore, Fairburn (2008) mentions “events and associated mood change” (p. 21) as an antecedent of binge eating. He highlights this process in his transdiagnostic model of eating disorders, indicating that negative mood can trigger binge eating in most eating disorder cases.

Binge eating, as well as purging and compensatory exercising, were found to be related to avoidant coping strategies (McFillin, 2009; Cooper & Murphy, 2021; Ball & Lee, 2000). These abnormal eating habits were depicted as dysfunctional attempts to regulate mood in many resources (Fairburn et al., 2003; Cooper & Murphy, 2021;

Oldershaw et al., 2015; Ball & Lee, 2000; Cooper & Dalle Grave, 2017). If we approach this notion from a social problem-solving perspective, one could utilize binge eating and related behaviors as problem-solving attempts to deal with the negative affect associated with life events. In support of this, many researchers reported that impulsivity predicts more severe symptoms in binge eating disorder (Boswell & Grilo, 2020) and bulimia nervosa (Myers et al., 2006; Fahy & Eisler, 1993; Fischer et al., 2003; Wiederman & Pryor, 1996). These findings suggest that IPS may exacerbate disordered eating.

1.4 Emotional Eating and Social Problem-Solving Skills

As previously discussed, food is now perceived as always available and can be used to cope with problems in daily life. Additionally, Bandura (1997) emphasized that if one experiences difficulties in managing stress, they might engage in eating in response to negative mood. In other words, he suggested that social and self-regulatory deficits have an influence on eating behaviors. Many researchers have studied this phenomenon since Bandura. Eating in response to affective states is recognized as emotional eating in the literature.

Gahagan (2012) states that human biological systems function to avoid starvation and maintain energy balance. However, these systems can deteriorate due to the influence of various factors. For example, excessively palatable food might encourage people to overeat (French et al., 2001). Most social activities are centered around food and eating, which might facilitate people to consume more food than usual (Kemp et al., 2013). Above all, a negative mood is a powerful incentive to eat, as palatable food enhances mood by activating the reward system. Building on this, Adam and Epel (2007) have proposed a theoretical model of Reward Based Stress Eating. Their model summarizes the process of stress-induced food intake, focusing on the repeated stimulation of the reward system. The model suggests that stress activates the reward pathways in the brain, possibly explaining why individuals engage in stress-induced eating as a coping mechanism to manage negative effects. This notion supports the previously mentioned argument: while psychological factors are decisive in the emotional eating process, it would be disorderly to ignore the influence of the food environment we currently live in. In contrast with our evolutionary past, various kinds of highly palatable and calorically dense food are easily accessible today (Allen, 2012/2021; Bandura, 1997). As a result,

there is a common tendency to use food to cope with stress. Kemp and colleagues (2013) report that this tendency exists in clinical and non-clinical samples.

Emotional eating is significantly associated with eating pathology (Reichenberger et al., 2021; Lindeman & Stark, 2001). The link between the two was frequently attributed to coping. For instance, Glynn and Ruderman (1986) report that individuals who did not have the efficacy beliefs to self-regulate their eating behaviors were more likely to overeat in response to negative emotions. Research also indicates that emotional eating is associated with poor emotion regulation skills (Burnatowska et al., 2022), which refers to “the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions” (Gross, 1988, p. 275). Drawing from the emotion regulation theory, the ability to use and control emotions in a constructive manner might facilitate or inhibit the problem-solving process. D’Zurilla and Nezu (2007) explain emotional reactions within the framework of problem orientation. Positive emotions (e.g., motivation, excitement) are likely to occur in response to problems when the problem-solver has a positive problem orientation. In contrast, negative emotions (e.g., fear) are more likely to occur in response when the problem-solver has a negative problem orientation. Moreover, Fairburn and colleagues (2003) refer to the belief of incapability while discussing eating disorders. If one believes that they are incapable of coping with negative feelings and thoughts, they are more likely to engage in disordered eating. This concept was proposed by Bandura (1977b) as self-efficacy expectations and was adapted to social problem-solving theory as problem orientation (Nezu, 2004). In this context, emotional eating can be explained with maladaptive social problem solving. The individual might believe that they are unable to meet the demands of the problem and choose to set goals for controlling or reducing the strong emotions induced by the problematic situation (D’Zurilla & Nezu, 2007). Since emotional eating is known to be one of those strategies used for altering strong emotions (Arnou et al., 1995), an individual with inefficient social problem-solving skills may be more likely to engage in emotional eating.

1.5 Intuitive Eating and Social Problem-Solving Skills

One could ask how eating exists as an innate experience and behavior without functioning as an attempt to cope or as a response to negative moods. Scholars of

psychology have been studying this form of eating as intuitive eating. This term refers to an adaptive form of eating that is autonomously conducted by the individual, according to the body's physiological signals (Giacone et al., 2024). An intuitive eater would listen to their bodily cues and determine when, what, and how much to eat (Tylka & Kroon Van Diest, 2013). This would separate one's eating from external factors, allowing authentic eating behaviors that fit the person's physiological needs to emerge.

According to the theory of intuitive eating, an intuitive eater would deal with negative emotions and events without using food as an attempt to cope (Tylka & Wilcox, 2006). Linardon (2021) stated that intuitive eating involves directly confronting negative thoughts and feelings "rather than trying to suppress or act on them" (p. 1974). This narrative aligns with the theory of social problem solving, which suggests that avoiding or impulsively responding to problems is often linked to the development of psychopathologies. Additionally, the author proposes that building intuitive eating may reduce the incidence of eating disorders. Further research supports this, indicating that intuitive eating is a protective factor against the development of eating disorders and disordered eating (Angeletti et al., 2024; Hazzard et al., 2021; Levine & Smolak, 2016).

While scholars of psychology have heavily focused on psychopathology, there has been growing recognition of the importance of studying psychological well-being (Vázquez et al., 2009). Keyes (2002) stated that "mental health remains the antonym of mental illness" (p. 208) while criticizing the perspective that defines mental health as the absence of psychopathological symptoms. In addition to emphasizing positive feelings and functioning, Keyes defines mental health as a cluster of emotional, psychological, and social well-being. Various studies consistently indicate that intuitive eating is associated with improved well-being and healthier eating attitudes (Van Dyke & Drinkwater, 2013), as well as increased body appreciation (Avalos & Tylka, 2006; Andrew et al., 2016) and body image flexibility (Linardon, 2022). It is also positively associated with adaptive social problem solving (Tylka & Wilcox, 2006). In summary, efficient social problem solving might be associated with eating in a way that is independent of mood regulation and coping. To contribute to studies of positive psychology, this study also focuses on intuitive eating and efficient social problem solving as possible protective factors against eating pathology.

1.6 Present Study and Hypotheses

Research indicates that social problem solving is linked to various psychopathologies (Eskin, 2013; Nezu et al., 2004; Nezu, 2004). In the scope of this study, I aim to understand the underlying mechanisms of the influence of social problem solving on eating pathology. The literature indicates that social problem solving might play a significant role in eating pathology. The main objective of this study was to suggest a reasonable alternative for explaining the relationship between problem solving and eating pathology. It is proposed that the findings will provide a better understanding of the association between transdiagnostic and eating-disorder-specific factors. Considering that eating pathology studies are scarce in the field of social problem solving, exploring the associations of social problem solving with eating pathology will contribute to the literature. Additionally, this study provides an opportunity to empirically test possible risk and protective factors.

Furthermore, I hypothesize that shape and weight over-evaluation, body dissatisfaction, and eating restraint are associated with APS, rather than IPS. Various theories indicate that preoccupation with eating and body weight is associated with avoidance of adverse stimuli, such as negative mood and events (e.g., Swanson et al., 2010; Slade, 1982). In addition, I propose that bingeing and purging are associated with IPS, rather than APS. These components have been studied in the context of impulsivity (Lavender & Mitchell, 2015) and have been suggested as mood stabilizers for individuals with eating pathology (Fairburn et al., 2003). Therefore, bingeing and purging can be impulsive attempts to improve the emotional state.

Drawing from the presented literature, I propose two mediation models to provide a comprehensive understanding of the mechanisms underlying the relationship between social problem solving and eating pathology. First, the mediator roles of emotional and intuitive eating will be tested independently in a parallel mediation model. This model suggests that inefficient problem solving is associated with eating in response to negative mood, which is termed emotional eating. In turn, emotional eating is suggested to contribute to eating pathology. On the other hand, efficient problem solving is expected to be associated with innate eating attitudes, also known as intuitive eating. In turn, intuitive eating is proposed to have a negative relationship with eating pathology. In other words, it is hypothesized that the more independent eating is from coping and the more

responsive it is to physiological needs, eating attitudes will be healthier. The second model will test the intervening roles of emotional and intuitive eating in a serial mediation model. The link between social problem solving and eating pathology will be investigated via the sequential emotional and intuitive eating chain. This model suggests that inefficient problem solving is associated with emotional eating, which is associated with less intuitive eating, which is finally associated with more eating pathology. Testing both models will provide a more comprehensive understanding of the mechanisms underlying the effect of intuitive eating and emotional eating. The hypotheses of the study are listed below, and the hypothesized models can be found in Figure 1.1 and 1.2.

H₁: Shape and weight over-evaluation, body dissatisfaction, and eating restraint are associated with APS, but not with IPS.

H₂: Binging and purging are associated with IPS, but not with APS.

H₃: Emotional eating and intuitive eating mediate the relationship between social problem solving and eating pathology.

H₄: Social problem solving influences emotional eating, which in turn affects intuitive eating, contributing to eating pathology.

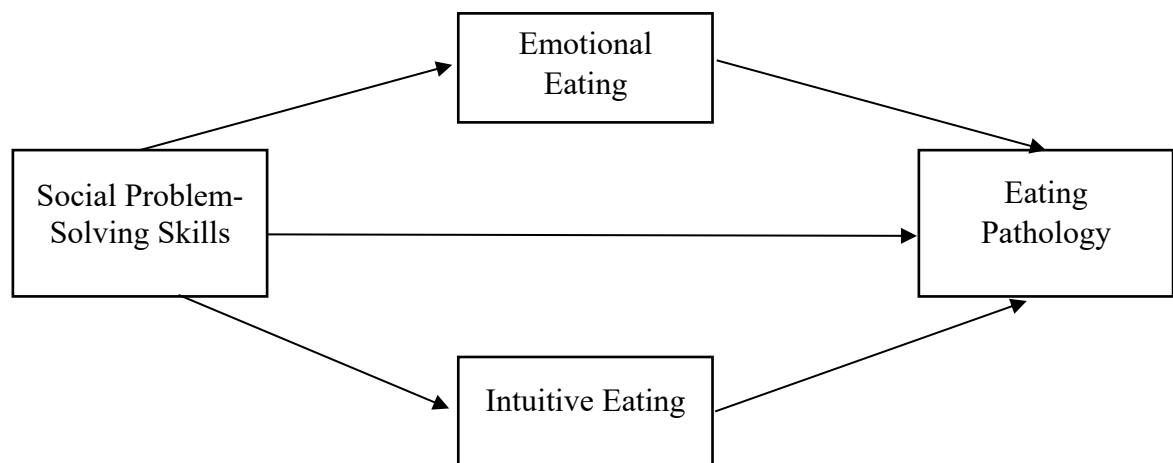


Figure 1.2: Hypothesized parallel mediation model.

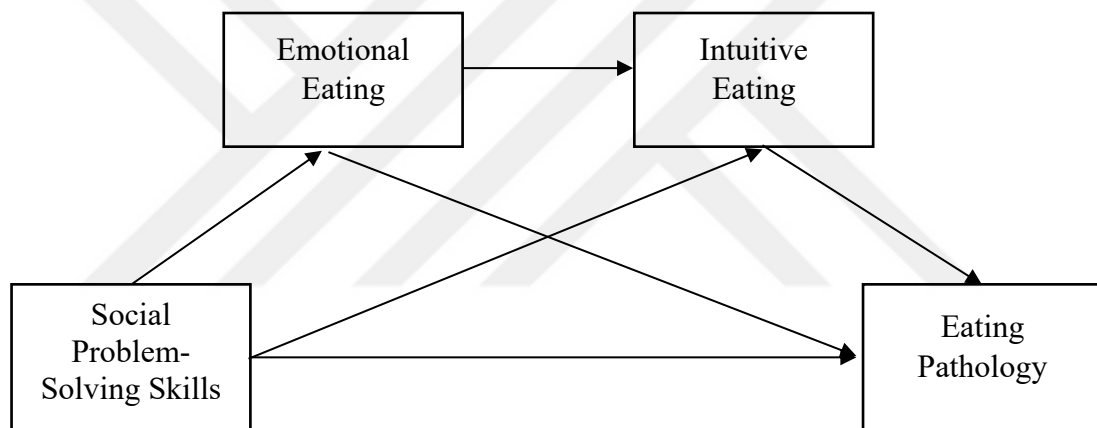


Figure 1.3: Hypothesized serial mediation model.

Chapter 2: METHOD

2.1 Design

A cross-sectional research design was deemed to adequately address the study's research questions. No interventions were implemented. The interpretations were based on existing differences at a certain time point between the variables. Social problem-solving skills serve as the independent variable in this study while eating pathology is the dependent variable. Intuitive eating and emotional eating were identified as mediator variables to study how this relationship occurs.

2.2 Participants

An a priori power analysis was conducted using G*Power software (Faul et al., 2009) to estimate the minimum sample size required to test the study hypotheses. The magnitude of the relationship between problem solving, eating pathology, intuitive eating, and emotional eating ranged from small to moderate in prior studies (see Arnow et al., 1995; Tylka & Wilcox, 2006; Smith et al., 2020; Prefit et al., 2019; Yönder-Ertem & Karakaş, 2020). To achieve 80% power at a significance criterion of $\alpha = .05$ and an expected small effect size of Cohen's $f^2 = 0.02$, the minimum required sample size was computed as 550.

Participants were recruited through an online survey platform, Qualtrics, and received no incentives. During the process of the data collection, I recorded 1059 responses in total. Only two exclusion criteria were set for this study: being outside the age range of 18-30 and not currently enrolled in a university degree program. 683 responses were excluded initially for the following reasons: (1) not approving the informed consent form (24 responses), (2) no responses except the approval of the informed consent form (206 responses), (3) no responses except the demographic form (348 responses), (4) withdrawing from the survey without rating all the items (105 responses). Only three individuals were removed from the final data set, as they did not meet the determined age criteria. In conclusion, 377 responses were included in the data analysis process. 304 participants (80.6%) identified as female, 71 (18.8%) identified as

male, and two (0.5%) identified as other (i.e., not identifying with any of the listed sex in the demographic form). Participants' ages ranged from 18 to 30 years ($M = 22.98$, $SD = 2.59$). Majority of the participants ($n = 353$, 93.6%) reported that they were single. The data indicated the sample consisted of mostly undergraduate ($n = 291$, 77.2%) and graduate students ($n = 62$, 16.5%). Nearly half of the participants have spent most of their life in metropolitan areas ($n = 180$, 47.7%). 37.4% of participants ($n = 141$) were accommodated in a dormitory, while 62.6% ($n = 237$) reported living in an apartment with their families or housemates. 14.6% of participants ($n = 55$) stated that they have received at least one psychological diagnosis in their lives. Because the desired sample size was not reached, Monte Carlo Power Analysis for the Indirect Effects (Schoemann et al., 2017) was conducted. Results indicated that the statistical power for the parallel mediation analysis was .89, while the power for the serial mediation analysis was .92. The elaborate sample characteristics can be found in Table 2.1.

Table 2.1: Sociodemographic characteristics of participants.

Variable	n	%
Sex		
Female	304	80.6
Male	71	18.8
Other	2	0.5
Marital Status		
Single	353	93.6
Married/Living with Partner	21	5.6
Divorced	2	0.5
Widowed	1	0.3
Educational Status		
Associate Degree	24	6.4
Bachelor's Degree	291	77.2
Master's Degree	52	13.8
Doctoral Degree	10	2.7
Living Arrangement		
In an apartment with housemates	40	10.6
In an apartment by myself	45	11.9
In an apartment with my family	151	40.1
In a dormitory with my roommates	134	35.5
In a dormitory by myself	7	1.9
Residential Area		
Country/Village	33	8.8
Town	2	0.5
District	64	17
City	98	26
Metropolis	180	47.7
Psychiatric Diagnosis		
Present	55	14.6
Non-Present	322	85.4

Note. $N = 377$. Participants were on average 22.98 years old.

2.3 Instruments

2.3.1 Informed Consent Form

The informed consent form includes detailed information about the purpose and the duration of the research, as well as the participants' rights to privacy and to withdraw from the study at any time (see Appendix A for the complete form).

2.3.2 Demographic Information Form

The demographic variables within the scope of this study were (1) birth date, (2) sex (i.e., female, male, or other), (3) marital status (i.e., married and/or living together with their partners, single, divorced, or widowed), (4) educational status (i.e., associate degree, bachelor's degree, master's degree, or doctoral degree), (5) living arrangement (i.e., in an apartment with housemates, in an apartment by myself, in an apartment with my family, in a dormitory with my roommates, or in a dormitory by myself), (6) monthly income (i.e., the total amount of their applicable scholarships and any financial support they received from their families), (7) residential area (i.e., country/village, town, district, city, or metropolis), (8) whether the participants have received any psychiatric diagnoses (i.e., yes or no), and (9) name of the psychiatric diagnosis (if applicable). The complete form can be seen in Appendix B.

2.3.3 Revised Social Problem-Solving Inventory

A Turkish adaptation of D'Zurilla and colleagues' (2002, as cited in Eskin & Ayca, 2009) Revised Social Problem-Solving Inventory was developed by Eskin and Ayca (2009). The adaptation was found to demonstrate adequate reliability and validity, with Cronbach's alphas for subscales ranging from .62 to .92. The internal consistency reliability of the SPSI-R for the current study sample was found to be good ($\alpha = 0.80$).

SPSI-R has a five-factor structure, compatible with the theory of social problem solving: (1) positive problem orientation (5 items, e.g., "When I have a problem, I believe I can solve it."), (2) negative problem orientation (10 items, e.g., "Instead of trying to solve my problems, I spend too much time worrying about them."), (3) rational problem-solving style (20 items, e.g., "While trying to solve a problem, I try to be creative and think of new and original solutions."), (4) impulsive/careless problem-solving style (10 items, e.g., "While making a decision, I do not evaluate every option carefully."), and (5) avoidant problem-solving style (7 items, e.g., "When a problem emerges in my life, I put off trying to solve it as far as possible."). SPSI-R consisted of 52 items, and the participants were asked to rate each item as *not at all true of me* (1), *slightly true of me* (2), *moderately true of me* (3), *very true of me* (4), or *extremely true of me* (5). Total social problem-solving skill scores and scores for each factor were calculated according to the measurement manual. Higher total scores indicate more effective social problem-solving

skills. For each factor, higher scores indicate a predisposition to that construct. The complete scale can be seen in Appendix C.

2.3.4 *Intuitive Eating Scale-2*

A Turkish version of Intuitive Eating Scale-2 (Tylka & Kroon Van Diest, 2013) was adapted by Akırmak and colleagues (2021). The Cronbach's alpha for the total IES-2 scores was .89, with estimates for the subscales ranging from .71 to .94. The internal consistency reliability of the IES-2 for the current study sample was good to excellent ($\alpha = 0.88$).

The Likert-type scale consisted of four subscales: (1) unconditional permission to eat (5 items, e.g., "I get angry at myself when I eat something unhealthy."), (2) eating for physical rather than emotional reasons (8 items, e.g., "I use food to soothe negative emotions."), (3) reliance on hunger and satiety cues (6 items, e.g., "I trust my body to guide me on what to eat."), and (4) body-food choice congruence (2 items, e.g., "I usually eat food that will provide my body with energy and endurance."). Among the 21 items, seven items (1, 2, 3, 6, 7, 8, and 9) were reverse-coded. The participants were asked to rate each item as *strongly disagree* (1), *disagree* (2), *neither agree or disagree* (3), *agree* (4), and *strongly agree* (5). Total intuitive eating scores and scores for each factor were calculated according to the measurement manual. Individuals more likely to eat intuitively are also likely to score higher on IES-2. The complete scale can be seen in Appendix D.

2.3.5 *Turkish Emotional Eating Scale*

A Turkish scale measuring emotional eating behaviors was developed by Bilgen (2018). TEES is a 30-item Likert-type scale consisting of four factors: (1) eating when nervous (11 items, e.g., "I eat more when I am stressed."), (2) eating to cope with negative emotions (10 items, e.g., "Food helps me cope with my emotions."), (3) self-control (6 items, e.g., "I eat when I am not hungry."), and (4) control against stimuli (3 items, e.g., "If I see and smell something delicious, I want to eat it."). Participants are asked to rate each item as *never* (1), *rarely* (2), *sometimes* (3), *usually* (4), and *almost always* (5). Three items (items 26, 28, and 29) are reverse coded. The maximum score available for this scale is 150 and higher scores indicate more frequent emotional eating behavior. While

Bilgen (2018) reported Cronbach's alpha values to be approximately .96 in the three-phase validation process, the internal consistency reliability of the TEES for the current study sample was found to be satisfactory ($\alpha = 0.97$). The complete scale can be seen in Appendix E.

2.3.6 *Eating Disorder Examination Questionnaire-13*

In their study comparing investigator-based interviews and self-report questionnaires, Fairburn and Beglin (1994) developed an eating disorder examination questionnaire. Since then, various versions of the questionnaire have been introduced. While some versions were shorter and easier to apply, they lacked some components such as binge eating or purging (Grilo et al., 2018). Lev-Ari and colleagues (2021) developed a new version of the eating disorder examination questionnaire, including binge eating and purging behaviors. This instrument appropriately measures the components in Fairburn's (2008) transdiagnostic eating disorders model. Esin and Ayyıldız (2022) adapted this questionnaire to Turkish and reported that EDEQ-13 possessed high levels of validity and reliability ($\alpha = .89$). Additionally, EDEQ-13 demonstrated good to excellent internal consistency for the current study sample ($\alpha = 0.89$).

The questionnaire consisted of 13 items related to the participants' disordered eating experiences in the past 28 days. Participants have rated each item as *0 days* (0), *1-5 days* (1), *6-12 days* (2), *13-15 days* (3), *16-22 days* (4), *23-27 days* (5), or *every day* (6). The factors in EDEQ-13 are (1) eating restraint (3 items, e.g., efforts made to change body weight and shape), (2) shape and weight over-evaluation (2 items, i.e., core psychopathology, dysfunctional system of self-evaluation), (3) body dissatisfaction (2 items, i.e., dissatisfaction with body weight and shape), (4) bingeing (3 items, e.g., loss of control over eating), and (5) purging (3 items, e.g., self-induced vomiting). Higher scores indicate higher eating pathology. The complete scale can be seen in Appendix F.

2.4 *Procedure*

Ethical approval for this study (2023.397.IRB3.174) was obtained from the Social Sciences Ethics Committee at Koç University, Istanbul, Turkey. The data collection period lasted from 24 January 2024 to 16 June 2024. Participants were recruited from social media platforms, email lists, and chat groups. Their first engagement with the

research was a poster and invitation letter informing participants of the research question, inclusion criteria, and approximate duration of the research. In addition, the contact information of the researcher was provided.

Participants were directed to the Qualtrics online survey platform to provide detailed information for the study. Initially, an informed consent form was presented to notify potential participants of their rights and the research objective. Only when the participants confirmed the informed consent form could they interact with the demographic form and the rest of the survey: SPSI-R, IES-2, TEES, and EDEQ-13. No personally identifying information was gathered. The survey lasted 24.43 minutes on average, according to the duration in second values provided by Qualtrics.

2.5 Data Analysis

SPSS Statistics for Windows, Version 28.0 (IBM Corporation, 2021) was used to conduct preliminary and statistical analyses. The mediation models were tested on PROCESS Macro (version 4.2) by Andrew F. Hayes. For the first model, social problem solving was assigned as the independent variable, while eating pathology was assigned as the dependent variable. Additionally, emotional eating and intuitive eating were assigned as the mediators, which allowed the analysis to explore their independent roles in the hypothesized relationship. For the second model, emotional eating and intuitive eating were added as serial mediators in the relationship between social problem solving and eating pathology, allowing us to analyze the sequential roles of the mediators.

Chapter 3:

RESULTS

This chapter presents the results of the following analyses: (1) associations of descriptives (i.e., age, sex, marital status, mental disorder diagnosis, residential context, education level, income, living arrangement) with study variables (i.e., social problem solving, emotional eating, intuitive eating, and eating pathology), (2) the relationship between eating pathology components and social problem-solving factors, (3) analysis of the hypothesized parallel mediation model in Figure 1, and (4) analysis of the hypothesized serial mediation model in Figure 2.

3.1 Preliminary Analysis

Preliminary analyses were conducted to form an understanding of the sample via descriptive statistics and to check if the data satisfied the assumptions required for statistical analyses. First, cases who withdrew from the study without completing the surveys were removed from the data set. Then, a missing value analysis was performed to see unanswered items. Little's MCAR test suggested that the missing values within SPSI-R ($\chi^2(421) = 404.904, p = .705$) and IES-2 ($\chi^2(20) = 19.294, p = .503$) were missing completely at random. Though TEES and EDEQ-13 failed to demonstrate completely random missingness ($p < .05$), analyses showed that the number of missing values were less than 5%. According to Tabachnick and Fidell (2014), "almost any procedure for handling missing values yields similar results" in this case (p. 97). Therefore, mean imputation was utilized in all instruments to replace missing values.

The skewness and kurtosis values for the total and subscale scores of SPSI-R supported the assumption of normality. Despite the moderate positive skew, the ages of participants also demonstrated normal distribution. However, the income of participants did not provide support for the assumption of normality, demonstrating a severely positively skewed and highly leptokurtic distribution. To perform a mediation analysis, the data set must fit the following assumptions: (1) linearity of the relationships between the independent, mediator, and dependent variables, (2) no multicollinearity, (3) normally distributed residuals, (4) independence of errors, and (5) homoscedasticity (Tabachnick & Fidell, 2014; Poole & O'Farrell, 1971). The scatterplots depicting the relationships

between study instruments revealed clear linear trends. No variables were highly correlated (e.g., $r > .90$, Tabachnick & Fidell, 2014). In addition, VIF values indicated that no multicollinearity was present in the data set. Skewness and kurtosis values indicated the normal distribution of residuals. Finally, the scatter plot indicated that the data fits the homoscedasticity assumption.

3.2 The Associations of Descriptives with Study Variables

The correlations among study variables, age, and income can be found in Table 3.1. Because income scores failed to meet the assumption of normality, Spearman's correlation coefficient was calculated instead of Pearson's. In summary, social problem solving was positively associated with intuitive eating ($r = .333, p < .001$) as well as the age of participants ($r = .143, p = .005$). In contrast, negative associations of emotional eating ($r = -.347, p < .001$) and eating pathology ($r = -.217, p < .001$) were present. Intuitive eating showed negative associations with emotional eating ($r = -.758, p = .000$) and eating pathology ($r = -.545, p = .000$). Emotional eating was found to be significantly correlated with eating pathology ($r = .505, p = .000$).

Table 3.1: Correlations among study variables, age, and income.

Variables	<i>M</i>	<i>SD</i>	1	2	3	4	5	6
1. SPSI_T	11.44	2.84	-					
2. IES_T	3.34	0.65	.333*	-				
3. TEES_T	78.89	27.12	-.347*	-.758*	-			
4. EDEQ_T	6.8	3.14	-.217*	-.545*	.505*	-		
5. Age	22.98	2.59	.143*	.036	.008	-.031	-	
6. Income	9763.84	10582.96	.049 ^a	-.020 ^a	.073 ^a	-.087 ^a	.277 ^{a*}	-

^aSpearman's correlation coefficient

* $p < .01$

SPSI-R scores demonstrated significant differences between educational status conditions ($F(3, 373) = 3.812, p = .010$). Post-hoc comparisons using the Tukey HSD test showed that social problem-solving levels of the associate degree group ($M = 11.67, SD = 2.76$) and the doctoral student group ($M = 14.48, SD = 2.48$) significantly differed in terms of social problem solving ($p < .05$). In addition, TEES scores showed significant differences among the conditions of living arrangement ($F(4, 372) = 3.369, p = .010$).

However, this difference did not remain significant in post-hoc comparisons using the Tukey HSD test ($p > .05$). No other statistically significant associations were found between SPSI-R, IES-2, TEES, or EDEQ-13 and the conditions of education level, marital status, living arrangements, or residential context ($p > .05$).

An independent samples t-test was conducted to compare the differences between diagnostic conditions. Individuals not diagnosed with a mental disorder scored significantly higher on social problem solving ($t(375) = -2.165, p = .031, 95\%CI [-1.70, -.081]$) and intuitive eating ($t(66.051) = -3.442, p = .001, 95\%CI [-.6, -.16]$). Moreover, participants with a diagnosis scored higher on emotional eating ($t(375) = -2.182, p = .030, 95\%CI [-1.7, -.09]$) and eating pathology ($t(375) = 3.136, p = .002, 95\%CI [4.57, 19.95]$). Elaborate statistics can be found in Table 3.2.

Table 3.2: t-test comparisons of study variables between diagnostic groups.

Variables	Mental Disorder Diagnosis				<i>t</i>	<i>p</i>	Cohen's <i>d</i>
	Present		Non-Present				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
SPSI_T	11.68	2.74	12.58	2.84	-2.165 ^a	.031	-.316
IES_T	3.02	.77	3.4	.61	-3.442 ^b	.001	-.592
TEES_T	89.36	30.82	77.1	26.07	3.136 ^a	.002	.458
EDEQ_T	7.85	3.2	6.62	3.1	2.710 ^a	.007	.395

^adf = 375

^bdf = 66.051

While examining the relationship between sex and social problem solving, the third category (i.e., other) was excluded due to having only two participants. According to the independent samples t-test results, male participants scored higher on social problem solving ($t(373) = -3.421, p < .001, 95\%CI [-1.99, -.54]$). Multivariate regression analysis demonstrated that the significant difference was only apparent in NPO ($Wilks' \Lambda = .880, F(1, 373) = 15.764, p < .001, R^2 = .078, Adjusted R^2 = .073$) and PPO ($Wilks' \Lambda = .894, F(1, 373) = 4.523, p = .011, R^2 = .024, Adjusted R^2 = .018$). Moreover, male participants scored higher in intuitive eating ($t(373) = -2.493, p = .013, 95\%CI [-.38, -.04]$). Meanwhile, female participants scored higher on emotional eating ($t(373) = 5.520, p = .010, 95\%CI [2.21, 16.16]$). No significant gender differences were observed in eating pathology ($p = .147$). Elaborate statistics can be found in Table 3.3.

Table 3.3: t-test comparisons of study variables between men and women.

Variables	Sex				<i>t</i> (373)	<i>p</i>	Cohen's <i>d</i>
	Female		Male				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
SPSI_T	12.19	2.83	13.46	2.71	-3.424	<.001	-.451
IES_T	3.30	.64	3.51	.64	-2.493	.013	-.329
TEES_T	80.66	26.90	71.48	26.97	2.589	.010	.458
EDEQ_T	6.92	3.11	6.32	3.27	1.454	.147	.341

After assuring that the data meets the assumptions, one-way multivariate analysis of variance (MANOVA) was conducted. Sex was entered as the fixed factor, while NPO, PPO, RPS, APS, and IPS were entered as the dependent variables. The results suggested that women and men significantly differed in terms of their social problem-solving skills ($F(5, 369) = 8.715$, $Wilks' \Lambda = .894$, $p = .000$, $partial \eta^2 = .106$). Tests of between-subjects effects indicated that these differences were only apparent in the NPO and PPO subscales. Women ($M = 32.29$, $SD = 9.25$) scored significantly higher than men ($M = 25.49$, $SD = 9.77$) on NPO ($F(1, 272) = 30.467$, $p = .000$), $partial \eta^2 = .076$). Additionally, women ($M = 17.24$, $SD = 3.78$) scored significantly lower than men ($M = 18.61$, $SD = 3.68$) on PPO ($F(1, 373) = 7.555$, $p = .000$, $partial \eta^2 = .020$). No significant differences in RPS ($p = .052$), APS ($p = .377$), or IPS ($p = .632$) were observed.

3.3 Eating Pathology Components and Maladaptive Social Problem-Solving Styles

Linear regression analyses were conducted to see the relationship between maladaptive social problem-solving styles and eating pathology components. For each EDEQ-13 factor, IPS and APS were entered as independent variables. The correlations between EDEQ-13 and SPSI-R factors can be found in Table 3.4, while the regression coefficients can be found in Table 3.5.

Table 3.4: Correlations between social problem-solving and eating pathology components.

Variables	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10
1. PPO	12.53	3.8	-									
2. NPO	21.06	9.72	-.499**	-								
3. RPS	50.02	13.41	.551**	-.182**	-							
4. APS	9.95	5.90	-.458**	.589**	-.253**	-						
5. IPS	10.43	6.74	-.225**	.298**	-.494**	.426**	-					
6. ER	2.72	1.78	-.013	.159**	.104*	.117*	.018	-				
7. SWOE	3.71	2.19	-.204**	.330**	-.032	.174**	.040	.553**	-			
8. BD	3.87	2.25	-.183**	.326**	-.004	.206**	.031	.465**	.812**	-		
9. Binging	2.23	1.43	-.088	.167**	-.070	.173**	.197**	.347**	.454**	.440**	-	
10. Purging	1.32	.83	.006	-.039	-.005	.071	.157**	.340**	.192**	.144**	.355**	-

* $p < .05$. ** $p < .01$.

Note. PPO = Positive Problem Orientation. NPO = Negative Problem Orientation. RPS = Rational Problem-Solving Style. APS = Avoidant Problem-Solving Style. IPS = Impulsive Problem-Solving Style. ER = Eating Restraint. SWOE = Shape and Weight Over-Evaluation. BD = Body Dissatisfaction.

Table 3.5: Coefficients from linear regression analysis for eating pathology and maladaptive social problem solving.

	Unstandardized Coefficients		Standardized Coefficients		
	<i>b</i>	<i>SE</i>	β	<i>t</i>	<i>p</i>
Weight and shape over-evaluation as the dependent variable					
IPS	-.013	.018	-.042	-.739	.461
APS	.071	.021	.192	3.417	.030
Eating restraint as the dependent variable					
IPS	-.010	.015	-.039	-.682	.496
APS	.040	.017	.134	2.355	.019
Body dissatisfaction as the dependent variable					
IPS	-.023	.019	-.069	-1.238	.216
APS	.090	.021	.235	4.212	.000
Binging as the dependent variable					
IPS	.032	.012	.151	2.708	.007
APS	.026	.013	.109	1.946	.052
Purging as the dependent variable					
IPS	.019	.007	.155	2.740	.006
APS	.001	.008	.005	.093	.926

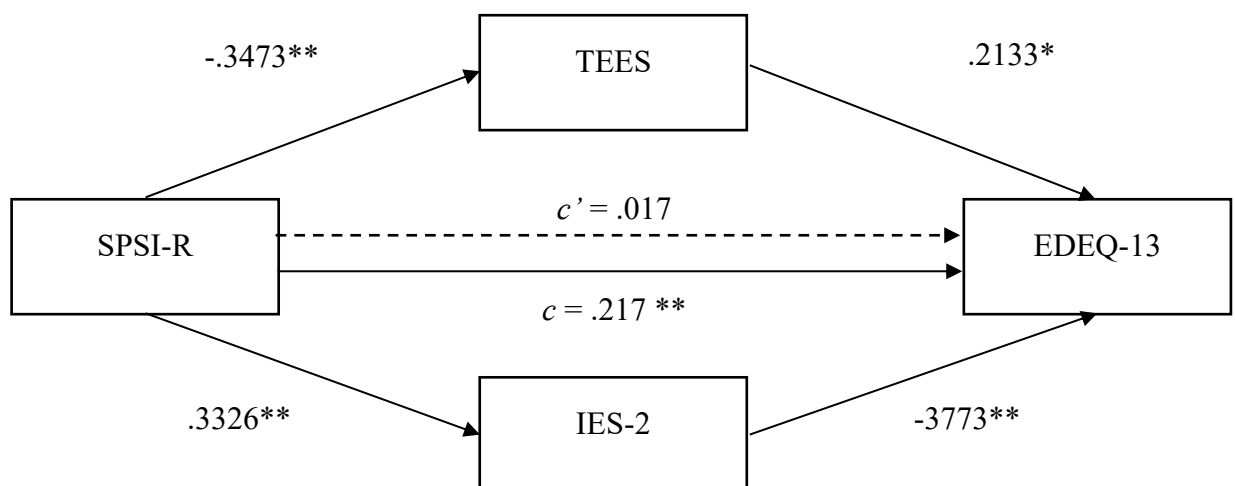
Note. IPS = Impulsive social problem-solving style. APS = Avoidant social problem-solving style.

The regression model, including APS and IPS, did not provide a significant explanation of ER ($F(2, 374) = 2.810, p = .62, R^2 = .015, R^2_{Adjusted} = .010$). However, APS was found to have a significant positive relationship with ER ($\beta = .133, t(374) = 2.350, p = .019$). IPS was not significantly associated with ER, accounting for APS ($\beta = -.041, t(374) = -.720, p = .472$). In the next model, SWOE was entered as the dependent variable and APS and IPS as independent variables. The model yielded significant results ($F(2, 374) = 6.191, p = .002, R^2 = .032, R^2_{Adjusted} = .027$), with APS significantly predicting WSOE ($\beta = .193, t(374) = 3.429, p = .001$). Again, IPS did not show any significant relationship with WSOE ($\beta = -.042, t(374) = -.749, p = .454$). In addition, BD was tested as a dependent variable in the next model. The results indicated a collective significant effect of APS and IPS ($F(2, 374) = 8.992, p < .001, R^2 = .046, R^2_{Adjusted} = .041$). APS demonstrated a significant relationship with BD ($\beta = .235, t(374) = 4.201, p < .001$), while IPS did not ($\beta = -.071, t(374) = -1.270, p = .205$).

While the model with APS and IPS yielded significant results ($F(2, 374) = 9.509, p < .001, R^2 = .048, R^2_{Adjusted} = .043$), APS was not associated with bingeing ($\beta = .109, t(374) = 1.961, p = .051$), accounting for IPS. IPS maintained the significance of its relationship with bingeing ($\beta = .150, t(374) = 2.685, p = .008$). Furthermore, purging was tested in a linear regression model. The model demonstrated significant results ($F(2, 374) = 4.651, p = .010, R^2 = .024, R^2_{Adjusted} = .019$). IPS was associated with purging ($\beta = .153, t(374) = 2.712, p = .007$), while APS was not ($\beta = .006, t(374) = .105, p = .916$).

3.4 Results of the Parallel Mediation Analysis

Following the guidelines of Hayes (2022), Model 4 was selected to test the mediating role of intuitive eating and emotional eating in the relationship between social problem solving and eating pathology. The total effect of SPSI-R on EDEQ-13 was statistically significant ($b = -.240, SE = .056, t(375) = -4.299, p = .000$). Indirect effects of IES-2 ($b = -.139, SE = .036, 95\% CI = [-.214, -.077]$) and TEES ($b = -.082, SE = .031, 95\% CI [-.148, -.024]$) were also significant. The direct effect of SPSI-R on EDEQ-13 was not statistically significant ($b = -.019, SE = .051, t(375) = -.372, p = .710$). These findings indicate that TEES and IES-2 fully mediate the relationship between social problem solving and eating pathology (see Figure 3.1). The predictors collectively explained 31.71% of the variance in EDEQ-13.



* $p = .001$, ** $p = .000$

Figure 3.1: Standardized regression coefficients for the parallel mediation model.

The reported parallel mediation analysis investigates the simultaneous roles of emotional and intuitive eating independently. Since the model examines different pathways for each mediation without assuming any connection among them, a serial mediation model was tested to better understand the relationship between social problem solving and eating pathology through intuitive eating and emotional eating. This more advanced model aims to reveal the step-by-step process by which SPSI-R affects EDEQ-13 through the chain of TEES and IES-2.

3.5 Results of the Serial Mediation Analysis

Utilizing Model 6 on PROCESS Macro (version 4.2), serial mediation analysis was conducted. The SPSI-R total score was assigned as the independent variable, while the EDEQ-13 total score was entered as the dependent variable. The hypothesized model suggests that maladaptive social problem solving (i.e., low SPSI-R total score) predicts higher emotional eating (i.e., higher TEES total score), then predicts lower intuitive eating (i.e., lower IES-2 score), and finally predict higher eating pathology (i.e., higher EDEQ-13 total score). In the model, the mediators are sequentially dependent on one another. Therefore, the mediators were added to the equation in the specified order.

The total effect for the relationship between SPSI-R and EDEQ-13 was statistically significant ($b = -.240$, $SE = .056$, $t(375) = -4.299$, $p = .000$). Additionally, the indirect effect from SPSI-R to TEES to EDEQ-13 ($a_1 \times b_1$) was significant ($b = -.221$, 95% $CI [-.301, -.150]$). The indirect effect from SPSI-R to IES-2 to EDEQ-13 ($a_2 \times b_2$) was also significant ($b = -.033$, 95% $CI [-.071, -.005]$). Furthermore, the indirect effect from SPSI-R to TEES to IES-2 to EDEQ-13 ($a_1 \times d \times b_2$) was statistically significant ($b = -.106$, 95% $CI [-.163, -.060]$). Lastly, the direct effect of SPSI-R on EDEQ-13 was not statistically significant ($b = -.019$, $SE = .051$, $t(375) = -.372$, $p = .710$), suggesting full mediation (see Figure 3.2). Again, the predictors collectively explained 31.71% of the variance in EDEQ-13.

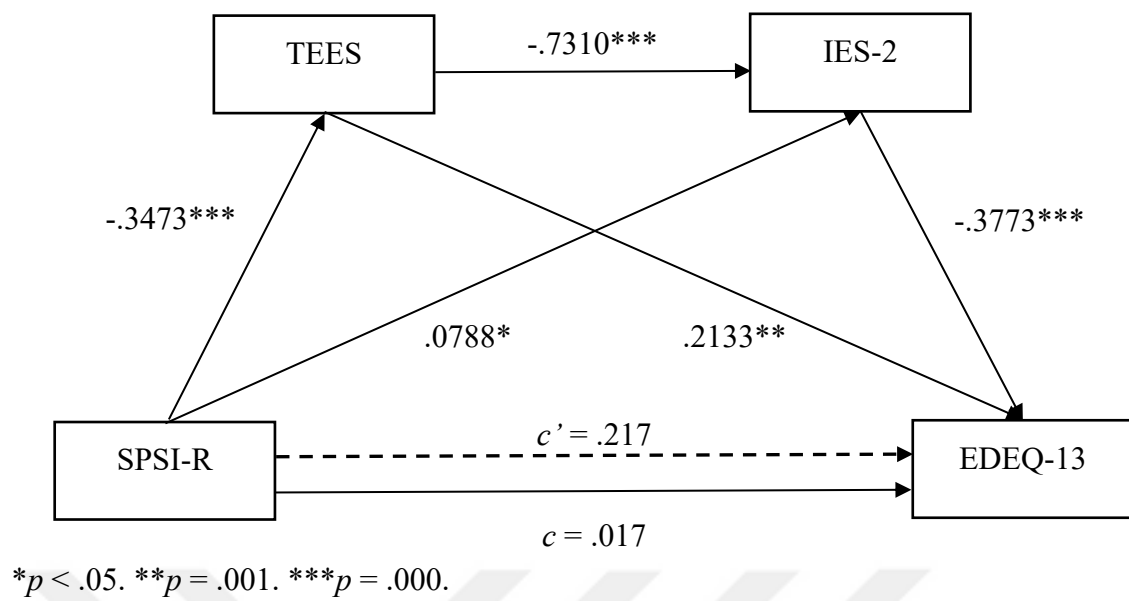


Figure 3.2: Standardized regression coefficients for the serial mediation model.

Chapter 4:

DISCUSSION

The purpose of the current study was to provide a comprehensive understanding of the social problem-solving mechanisms underlying eating pathology. Self-report measures were used to assess the study variables. First, demographics were analyzed to see how social problem solving, intuitive eating, emotional eating, and eating pathology differ across the sample. The main objective was to investigate the mediating roles of intuitive eating and emotional eating in the relationship between social problem solving and eating pathology. Both serial and parallel mediation models were tested to address this complex relationship. Additionally, associations of abnormal eating behaviors (e.g., purging) by APS and IPS were examined by linear regression analyses. Overall, results confirmed that social problem-solving processes might explain eating pathology by the influence of coping-related eating variables. In other words, inefficient problem solving might drive individuals to act on the tendency to cope with issues by eating. This process exacerbates intuitive eating by increasing emotional eating, which ultimately makes pathological eating behaviors more frequent. Furthermore, certain eating pathology components (i.e., eating restraint, weight and shape over-evaluation, and body dissatisfaction) that maintain a preoccupation with body weight and shape and eating were found to be associated with APS. The remaining factors of eating pathology (i.e., bingeing and purging) were found to be associated with IPS, as they functioned as impulsive attempts to regulate mood. The results of the statistical analyses and their interpretations are elaborately discussed below.

4.1 The Relationships Between Descriptives and Study Variables

SPSI-R scores were positively correlated with age, indicating that there might be a tendency to improve social problem solving with growth and maturation. This finding aligns with the literature. For instance, D’Zurilla and colleagues (1998) reported that social problem-solving skills tend to increase from young adulthood to middle age, demonstrating better PPO and RPS. Additionally, disordered eating behaviors become less common as age advances (Hadjigeorgiou et al., 2018). Although the current study failed to find any significant relationship between age and eating pathology, the tendency

to improve social problem solving with age might also serve as a factor that reduces the frequency of coping attempts by eating.

Male participants scored significantly higher than female participants on SPSI-R. Because the results of prior studies are conflicted, this finding might not suggest a simple gender difference. For instance, Ramadan and McMurran (2005) reported no significant differences in social problem solving between males and females. Other studies report much more complex gender differences moderated by age and context (D’Zurilla et al., 1998; Green et al., 2008). Additionally, MANOVA results showed that only NPO and PPO differed among sexes, which indicates that males have more cognitive and emotional self-efficacy to deal with daily life issues. Various studies in the literature support this finding. Luo et al. (2023) reported that male participants reported higher creative self-efficacy, which is crucial for generating solution alternatives (Nezu et al., 2013; D’Zurilla & Goldfried, 1971). Hackett and Betz (1981) stated that women’s socialization and learning experiences are extremely restricting, and women report low expectations of success in many fields. The authors also reported that low self-efficacy is such a “strong internal barrier” (p. 337) that it prevents women from considering multiple alternatives and effectively making decisions. Both processes are critical in the social problem-solving process, which might explain the higher scores of men. However, social problem-solving theory suggests that NPO predicts maladaptive social problem-solving styles, which was not the case for the female participants in this study. Their scores did not significantly differ from the male participants’ scores in terms of RPS, APS, and IPS. Similarly, Clement (1987) reported that women’s actions did not seem to be influenced despite having lower self-efficacy. Accordingly, though women report more NPOs, they might not withdraw from dealing with social issues, which would allow them to become skillful at social problem solving. This narrative might explain the insignificant differences between the two sexes in terms of problem-solving styles, despite the significant difference in problem orientations.

The remaining demographics did not demonstrate any significant differences across the conditions. The one exception was the difference in SPSI-R between the doctoral student group and the associate degree group. This difference can be explained by the significantly different mean ages between the groups, as age and SPSI-R were positively correlated. However, the doctoral student group ($M = 28.4$, $SD = 2.73$) was not the only group that significantly differed from the associate degree group ($M = 21.96$, SD

= 2.73, $p = .000$). Master group ($M = 25.87$, $SD = 1.73$) also significantly differed in terms of age ($p = .000$), while no differences in SPSI-R scores were observed between the master's and associate degree groups ($p > .05$). Therefore, the observed difference between the extreme levels of educational status may be due to the reported level of education of the participants.

Social problem solving was negatively correlated with eating pathology, aligning with previous research. Moreover, diagnosed group significantly scored lower on SPSI-R. The significant relationship between problem solving and psychopathology has been emphasized many times in previous research. Eating disorders and problem-solving skills were also found to be associated in prior studies, though the scope of studies were not inclusive of many eating pathology factors. For instance, Sternheim and colleagues (2012) reported that compared to healthy controls, individuals with anorexia nervosa experienced difficulties with implementing solutions. Paterson et al. (2011) also reported that anorexia nervosa is significantly associated with the lack of PPO, as well as higher scores of NPO and APS. Additionally, Tylka and Wilcox (2006) reported a negative relationship between disordered eating and social problem solving. Current research provides another evidence for the relationship between psychopathology and social problem solving, also contributing to the literature by demonstrating a significant relationship between eating pathology and social problem solving.

4.2 The Relationships Between Eating Pathology and Social Problem-Solving Components

The current study also examined the transdiagnostic eating disorder components with their relation to social problem solving. NPO was associated with all components of eating pathology, in accordance with the literature (Paterson et al., 2011; Swanson et al., 2010; Paterson et al., 2007). NPO is associated with low self-efficacy and perceived lack of control, which are significant processes in eating pathology (Keshen et al., 2017; Dalglish et al., 2001). Social problem-solving theory includes three problem-solving styles, two of which are maladaptive: APS and IPS. To explain the nature of eating pathology on the basis of social problem solving, eating pathology factors were investigated in terms of maladaptive problem-solving styles. Weight and shape over-evaluation, body dissatisfaction, and eating restraint were solely associated with APS,

while bingeing and purging were solely associated with IPS. As mentioned in the introduction, being excessively occupied with body weight and shape avoids adverse stimuli such as negative life events. In the words of social problem-solving theory, an individual could develop an excessive occupation with body weight and shape to avoid facing social life issues. The same mechanism could work for the maintenance of eating pathology.

According to the correlation analysis, bingeing was the only eating pathology component associated with APS and IPS. However, the results of the linear regression model suggest a further interpretation because the significant relationship between APS and bingeing was not maintained when IPS was introduced to the model. This finding suggests that the relationship between social problem solving and bingeing might be largely explained by IPS. However, the literature does not have a consensus on this matter. For instance, Swanson and colleagues (2010) did not report significant differences in IPS between anorexia nervosa and healthy controls. Juarascio et al. (2011) did not find a moderating effect of impulsivity in the relationship between BD and disordered eating. In contrast, Paterson et al. (2011) reported a significant difference between anorexic and healthy control groups in terms of IPS. The present study may help explain these conflicting findings in the literature. The results suggest that eating pathology cannot be explained by a single problem-solving process. Different social problem-solving processes might predict different pathological eating behaviors. Individuals with a stronger tendency to adopt IPS might engage in bingeing and purging more frequently. On the other hand, individuals with a stronger tendency to adopt APS could be more preoccupied with body and eating, resulting in an excessive dietary restraint and discontent with the body. In conclusion, weight and shape over-evaluation could manifest itself as eating pathology symptoms based on the levels of IPS and APS. Furthermore, pathological eating behaviors might differ in functions. Individuals could engage in binge eating to improve their emotional states and manage negative effects (Pearson et al., 2014; Schag et al., 2013). Purging could also serve as a mood stabilizer to cope with feelings of shame and guilt that emerge after an episode of binge eating (MacDonald et al., 2022). These findings enforce the idea that in terms of social problem solving, bingeing and purging could function as emotion-focused impulsive attempts to cope with social life issues. Additionally, because social problem-solving processes are linked with certain

eating patterns, the findings of the study may help differentiate between different clinical presentations of eating pathology.

4.3 *The Results of the Mediation Analyses*

H_3 and H_4 proposed models explaining the indirect path between SPSI-R and EDEQ-13. Both models were consistent with the current study's data, indicating that these models are reasonable candidates for explaining the association between social problem solving and eating pathology. H_3 recommended a parallel mediation model, where IES-2 and TEES were entered as independent mediators in separate pathways. The results suggest that maladaptive social problem solving predicts emotional eating and then higher eating pathology. On the other path, adaptive social problem solving predicts lower eating pathology by the mediating role of intuitive eating. This model suggests that the less competent an individual is in social problem solving, the more likely they are to use eating to cope with negative emotions, thereby increasing eating pathology. Additionally, the more efficient problem solving an individual reports, the more likely they will eat for physical reasons rather than emotional ones. This path results in lower eating pathology, indicating that efficient problem solving predicts less eating pathology via intuitive eating. Direct effect of SPSI-R on EDEQ-13 was insignificant after accounting for IES-2 and TEES, which indicates that intuitive eating and emotional eating fully mediate the relationship between social problem solving and eating pathology.

H_4 suggested a possible relationship between intuitive eating and emotional eating, placing them on the same path between social problem solving and eating pathology. This model indicates that lower SPSI-R predicts higher TEES, lower IES-2, and higher EDEQ-13. According to this model, an individual who adopts less effective problem solving will be more likely to eat in response to negative moods and events, decreasing intuitive eating and, in the end, increasing eating pathology. Just as the parallel mediation model tested for H_3 , the serial mediation model provided evidence for full mediating effects of emotional and intuitive eating. In conclusion, both emotional and intuitive eating explain the relationship between social problem solving and eating pathology. Their influence contributes to eating pathology both in sequential and independent mechanisms.

4.4 Clinical and Theoretical Implications

Explaining eating pathology from the perspective of social problem solving might allow us to work on abnormal eating behaviors during problem-solving therapy. Problem-solving therapy (PST) is an evidence-based form of cognitive-behavioral therapy (Eskin, 2013). In the process of PST, IPS, APS, and NPO are identified and targeted for reduction. The main objective of PST is to promote adopting PPO and RPS. The results of this study suggest that in PST, bingeing and purging behaviors can be approached as IPS strategies, while eating restraint, over-evaluation, and body dissatisfaction complaints can be approached as manifestations of APS. In addition, mediation analyses indicate that social problem-solving interventions should be utilized to decrease emotional eating and encourage intuitive eating. The findings of this study suggest that maladaptive social problem solving and emotional eating might be risk factors for eating pathology, while adaptive social problem solving and intuitive eating are protective factors against eating pathology. Furthermore, Babbott and colleagues (2022) reported that developing intuitive eating skills can promote adaptive eating in individuals with eating disorders, suggesting that intuitive eating is also a promising addition to the treatment of eating disorders. As mentioned before, improved problem-solving skills can enhance intuitive eating by separating eating from coping. In conclusion, implementing social problem-solving interventions in the treatment of eating disorders might assist patients and clinicians in the therapeutic process.

One of the most robust treatment methods for eating disorders is enhanced cognitive behavioral therapy (CBT-E) (de Jong et al., 2018). CBT-E describes a therapeutic process that concerns general eating pathology rather than specific eating disorder diagnoses (Fairburn et al., 2008). In other words, this type of CBT is based on the notion that all eating disorder diagnoses include similar characteristics (Favaro et al., 2003). It identifies the processes that maintain the core psychopathology and targets the dysfunctional self-evaluation system in treatment (Fairburn et al., 2003). Additionally, CBT-E is strongly associated with Fairburn's (2008) transdiagnostic model of eating disorders. Therefore, I propose the possibility that APS and IPS might account for some of the links in Fairburn's transdiagnostic model. The addition of APS and IPS reinforces the idea that PST has the potential to achieve significant changes in abnormal eating behaviors. Drawing from the paths I tested, I propose that over-evaluation could be

associated with non-compensatory body weight and shape control behaviors (NCB) when APS is higher, possibly leading to binge eating if IPS operates. APS may also play a role in moderating the path between NCB and significantly low body weight, as the findings indicate a potential link between higher avoidance and higher eating restraint. IPS is indicated to moderate each path associated with binge eating and compensatory control behaviors, as the results indicate the possibility that these behaviors might serve as impulsive emotion-focused strategies. Lastly, higher IPS might be associated with higher binge eating when faced with negative event and associated mood change. However, the reader is advised to keep in mind that this study did not provide evidence for the validity of these additions. Future studies are needed to test the model and explore how the social problem-solving process operates in the course of eating disorders. The model with the addition of these hypothetical paths can be found in Figure 4.1.

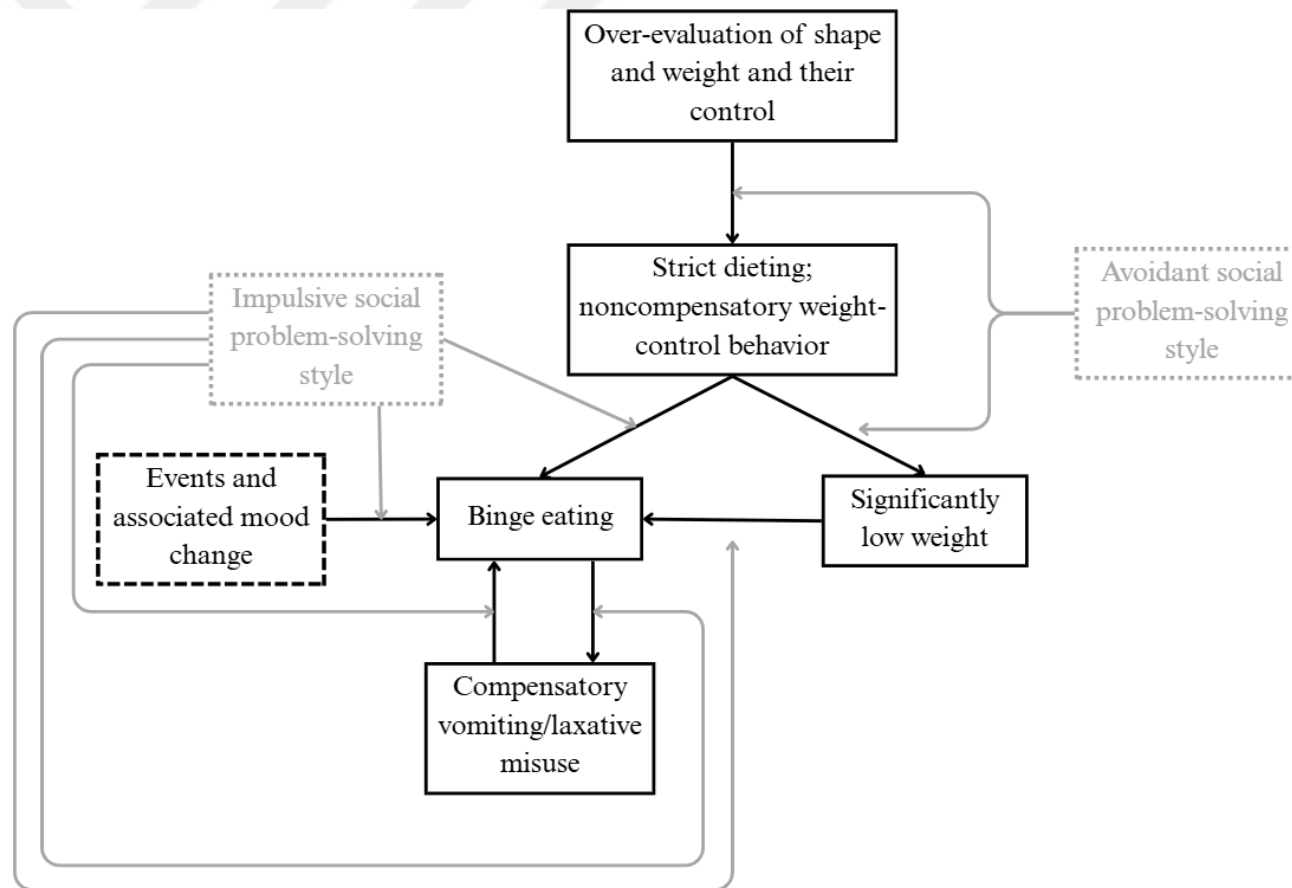


Figure 4.1: Hypothesized model of maladaptive social problem-solving styles moderating the paths in transdiagnostic eating disorders model.

Note. Adapted from Cognitive Behavior Therapy and Eating Disorders by Christopher G. Fairburn. © 2008 by The Guilford Press.

The model in Figure 4.1 indicates the possibility that social problem solving might be an effective treatment method not only as a complement to existing eating disorder treatments but also as an independent treatment approach. From the current understanding, the magnitude of APS may play a role in shaping NCB, such as strict dieting. IPS could influence objective and subjective bingeing, and additionally, compensatory weight and shape control behaviors such as self-induced vomiting. By targeting these behaviors, one might be able to challenge the over-evaluation of body weight and shape and their control, which is the core psychopathology of eating disorders.

One shortcoming of the proposed model is that it may not fully represent the eating disorder cases that do not engage in bingeing. However, the addition of IPS allows us to evaluate the disorder on a spectrum. For instance, an individual who is at the lower end of the IPS spectrum may not frequently engage in binge eating and compensatory control behaviors. Assuming that the same individual is on the higher end of the avoidant problem-solving spectrum, the clinical presentation could be more closely associated with anorexia nervosa pathology. In support of this, Fairburn's (2008) restricting anorexia nervosa model ends with the consequences of strict dieting, which was termed as a non-compensatory weight-control behavior. These consequences include preoccupation with eating and social withdrawal, which might be the outcome of avoidance of negative events and emotions.

4.5 Strengths, Limitations, and Future Directions

While social problem solving has been studied with various psychopathologies (Nezu, 2004), social problem-solving studies on disordered eating and eating disorders are scarce compared to mood and anxiety disorders. In this study, I aimed to investigate the relationship between eating pathology and social problem solving. Additionally, I discussed their association in detail. Since the nature of eating disorders is not yet fully understood, the findings of this study may enhance our understanding of eating disorders.

Even though the present research offers valuable insights into how eating pathology is developed and maintained, it is limited in various aspects. For instance, the desired sample size could not be achieved in the limited timespan of this study. However, power analyses indicated that the statistical analyses in the current study demonstrated more statistical power exceeding satisfactory levels (.80; Tabachnick & Fidell, 2014).

Although the sample was not as large as desired, the study does not seem to suffer from insufficient statistical power. Nevertheless, the sample possesses other issues, mainly related to its demographic characteristics. First, the inclusion criteria for the study were specified as university students. In a recent study, Novielli and colleagues (2023) reported significant differences in mental health and response characteristics between a community sample and a college student sample. Similar differences might have influenced the findings of the current study. Additionally, most participants were on the higher end of socioeconomic status. This raises concerns about the validity of the results, as individuals who reported lower socioeconomic status also reported that their eating attitudes were influenced by financial concerns (Bukman et al., 2014). Furthermore, the sample consisted of mostly female individuals. Because men and women differ in their experience of eating and body weight and shape, the unbalanced distribution of gender is a major limitation. While women reported their ideal figures to be thin, men reported theirs to be muscular (Grossbard et al., 2011). These ideals require different eating habits. A thin body might require fat loss by creating a calorie deficit, while a muscular body might require an emphasis on protein intake (Babrova et al., 2025). Moreover, men are underrepresented in the eating disorder literature (Weissman, 2019). Measures and assessments of eating disorders are mostly focused on women's experience of body discontent and eating behaviors (Richardson & Paslakis, 2021). Eating pathology measures demonstrate lower reliability in men than in women (Forbush et al., 2017). Additionally, how eating pathology influences psychological health also differs across genders. Mehak and Racine (2019) reported that feeling fat was more relevant to clinical impairment in women than men. Furthermore, Blashill (2011) also reported that eating pathology and body dissatisfaction differs among sexual orientations. Unfortunately, current study did not present any questions to the participants on their sexual orientation. In conclusion, one should keep in mind that this sample and measures are not representative of all genders and sexual identities. The results should be replicated in more representative samples to make valid implications.

Furthermore, the lack of significant differences between the other conditions of demographics might be due to an unbalanced design and lack of statistical power. Unbalanced design stands for unequal cell frequencies and may occur in non-experimental research (Graefe et al., 2023; van Ginkel & Kroonenberg, 2021). This is indeed an issue in the current study. One instance is the difference between bachelor's

degree ($n = 291$) and doctorate degree ($n = 10$) conditions, possibly explaining the lack of significant differences. Additionally, according to Cohen's (1992) guidelines, most conditions in the current study do not meet the required minimum sample size. This indicates that the sample lacked representativeness and statistical power. Considering that post-hoc tests are even lower in power (Collins & Watt, 2021), disappearing significant differences in post-hoc tests of TEES scores is to be expected. In conclusion, one should address the lack of generalizability while interpreting the results.

This is a correlational study, thus, the results should be implemented accordingly. Although the serial mediation model suggested that emotional eating is related to decreased intuitive eating, the reverse path could also apply: deviation from intuitive eating might predict increased emotional eating, subsequently increasing eating pathology. Another concern is the high correlation between intuitive eating and emotional eating ($r = -.758$). According to Tabachnick and Fidell (2014), correlations higher than $r = .90$ might indicate multicollinearity. While the relationship between the two mediators in this study is lower, it might still suggest a conceptual overlap. Indeed, intuitive eating includes a dimension for eating for physical rather than emotional reasons, which might partially account for this relationship. However, VIF values remained within acceptable limits, suggesting that emotional eating and intuitive eating might have contributed uniquely to the model. Therefore, the analyses were still conducted in accordance with the hypotheses.

As the design is cross-sectional, the nature of this study does not allow for investigating any causal relationships. Although full mediation was observed, this only indicates that the model is consistent with the data. It does not rule out other variables that might explain eating pathology. For example, the influence of sociocultural factors on eating attitudes is widely recognized (Weissman, 2019; Stice, 2002). The media, family, and peers influence individuals through social reinforcement and modeling processes (Stice, 2002). As a result, thin idealization and fit appearance are promoted, while excess weight is denigrated. This study has left out relevant sociocultural factors that is associated with eating attitudes, and the reader is advised to keep this in mind while interpreting the results.

Furthermore, the measures used in this study were based on self-report, which is susceptible to response biases. For social problem solving, researchers suggest that SPSSI-R may be unable to detect variability in real-life problem solving (Anderson et al., 2009;

2011). Similar concerns have been raised for emotional eating (Reichenberger et al., 2020; Bongers & Jansen, 2016; Schneider et al., 2012), with ongoing debates on whether emotional eating exclusively refers to food intake as a response to negative emotions. Cardi and colleagues (2015) reported that greater food intake was also associated with enhanced positive mood. In the scope of this study, an instrument that solely measures eating in response to negative mood and events was utilized, as coping with negative moods and events was the main focus.

Although the mediation analyses yielded significant results, they lack certain perspectives. For instance, it would not be accurate to claim that every individual who lacks adaptive social problem-solving skills engages in emotional eating. Another variable that increases the likelihood of emotional eating must be present, which in turn increases eating pathology. Additionally, not every individual who eats emotionally develops pathological eating behaviors. Therefore, future research should consider elaborating these paths with additions of potential moderator variables.

PST can help separate eating from adverse events and mood and reinforce food intake as an innate behavior to satisfy hunger and satiety needs. The therapist could approach bingeing and purging as emotion-focused impulsive strategies while approaching over-evaluation, eating restraint, and body dissatisfaction as manifestations of avoidance of problems. The next step following this research should be to test the effectiveness of problem-solving training and therapies in individuals with disordered eating or eating disorders. Since PST offers the possibility of transdiagnostic applications like CBT-E, evaluating the unique efficacy of PST in individuals diagnosed with eating disorders is also an option. Integrating social problem-solving interventions into CBT-E could be explored to enhance treatment efficacy, possibly addressing the shortcomings of current treatments, such as high relapse rates. Testing PST as an alternative treatment could provide a wider range of evidence-based treatment options for eating disorders. Either way, social problem solving is beneficial in both theoretical and clinical fields in addressing eating pathology. The results of this study indicate that social problem solving is a promising framework for researchers and therapists who wish to work on eating behaviors. Social problem-solving interventions could serve as a primary or supportive treatment method for eating disorders and disordered eating behaviors.

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Appendix A: Informed Consent Form/Bilgilendirilmiş Onam Formu

Koç Üniversitesi Sosyal Bilimler Enstitüsü Psikoloji bölümü öğretim üyesi Prof. Dr. Mehmet Eskin danışmanlığında Klinik Psikoloji yüksek lisans programı öğrencisi Sıla Özer tarafından yürütülen, Koç Üniversitesi Etik Kurullarının 2023.397.IRB3.174 sayılı onayı ile izin verilen, “Sorun Çözme Becerileri Yeme Patolojisini Nasıl Etkiliyor? Duygusal Yeme ve Sezgisel Yemenin Aracı Rolü” başlıklı yüksek lisans tezi kapsamında yapılan araştırmaya katılımınız rica olunmaktadır. Bu araştırmaya tamamen kendi iradenizle, herhangi bir zorlama veya mecburiyet olmadan gönüllü olarak katılımınız esastır. Bu sebeple aşağıdaki bilgileri okumanız ve katılmaya karar vermeden önce anlaşılmayan herhangi bir husus var ise sorumlu araştırmacıya sormanız önem arz etmektedir.

Söz konusu araştırmanın amacı, günlük hayatta karşılaştığımız problemleri nasıl algıladığımızın ve bu problemleri çözme tarzımızın yeme davranışlarımızı nasıl ve hangi tutumlar aracılığıyla etkilediğini incelemektir. Araştırma, ülkemizde ve dünyada görülme sıklığı git gide artan yeme bozukluklarının daha iyi anlaşılması ve sağlıklı yeme davranışlarının tedavisi ve önlenmesinde yeni yöntemlerin önünün açılmasına katkı sağlayacaktır. Çalışmanın tamamı için ayırmanız gereken süre yaklaşık 15 dakikadır. Bu çalışmaya gönüllü katılmak istemeniz halinde bir demografik bilgi formunun yanında sorun çözme becerileri ve yeme davranışları ile ilgili dört ölçek doldurmanız istenecektir. Ziyaretiniz boyunca bu siteden ayrılmanız veya başka bir siteyi ziyaret etmeniz gerekmeyecektir. Bu çalışmayla bağlantılı olarak elde edilen ve sizinle özdeşleşmiş her bilgi yalnızca bu araştırma kapsamında kullanılacak, kimliğinize dair herhangi bir bilgi toplanmayacak ve saklanmayacak, sağladığınız bilgiler herhangi bir üçüncü kişiyle paylaşılmayacak ve bu bilgilere yalnızca araştırmayı yürüten kişi ile danışmanı ulaşabilecektir.

Bu çalışmanın içinde olmak isteyip istemediğinize tamamen kendi iradenizle ve etki altında kalmadan karar vermeniz önemlidir. Katılmaya karar verdikten sonra, herhangi bir anda sahip olduğunuz herhangi bir hakkı kaybetmeden veya herhangi bir yaptırıma maruz kalmadan istediğiniz zaman ayrılabilirsiniz. Herhangi bir sorunuz veya endişeniz varsa lütfen iletişime geçiniz.

Appendix B: Demographic Information Form/ Demografik Bilgi Formu

- 1) Doğum tarihiniz:
- 2) Biyolojik cinsiyetiniz:
 - ☐ Kadın
 - ☐ Erkek
 - ☐ Diğer
- 3) Medeni durumunuz:
 - ☐ Bekar
 - ☐ Evli ve/veya partneriyle birlikte yaşıyor
 - ☐ Boşanmış
 - ☐ Eşi vefat etmiş
- 4) Eğitim durumunuz (şu anda devam etmekte olduğunuz öğreniminiz):
 - ☐ Ön lisans
 - ☐ Lisans
 - ☐ Yüksek lisans
 - ☐ Doktora
- 5) Öğrenciliğiniz boyunca nerede konaklıyorsunuz?
 - ☐ Evde, ev arkadaşlarımla
 - ☐ Evde, tek
 - ☐ Evde, ailemle
 - ☐ Yurtta, oda arkadaşlarımla
 - ☐ Yurtta, tek başıma
- 6) Aylık geliriniz (burslar, ailenizden alıyorsanız aldığınız maddi destek, çalışıyorsanız geliriniz dahil şekilde):
- 7) Yaşamınızın büyük çoğunluğunu nerede geçirdiniz?
 - ☐ Köy
 - ☐ Kasaba
 - ☐ İlçe
 - ☐ Şehir
 - ☐ Büyükşehir
- 8) Son zamanlarda herhangi bir psikiyatrik tanı aldınız mı?
 - ☐ Evet
 - ☐ Hayır
- 9) Cevabınız evet ise, ne zaman ve hangi tanıyı aldınız?

Appendix C: Revised Social Problem-Solving Inventory/Gözden

Geçirilmiş Sosyal Sorun Çözme Envanteri

YÖNERGE: Aşağıda, insanların günlük yaşamda sorunlarla karşılaştıkları zaman gösterebilecekleri bazı düşünce, duygu ve davranış biçimleri verilmektedir. Bu ankette geçen, “sorun” kelimesi ile yaşamınızda önemli bulduğunuz ve sizi çok rahatsız eden ama nasıl düzelteceğinizi bilmediğiniz durumlar kastedilmektedir. Sorun, sizin kendinizle (düşünceleriniz, duygularınız, davranışınız, sağlığınız veya görünümünüz ve benzeri), diğer insanlarla olan ilişkilerinizle (aile, arkadaş, öğretmen, veya patron ve benzeri), veya çevreniz ve sahip olduklarınızla (ev, araba, mülk, veya para ve benzeri) ilgili olabilir. Lütfen aşağıdaki her bir ifadeyi dikkatlice okuyunuz ve o ifadenin sizin için ne derece geçerli olduğuna karar veriniz. Burada verilebilecek cevapların doğrusu veya yanlışı yoktur. Sorunlarla karşılaştığınızda nasıl düşündüğünüzü, hissettiğinizi ve davrandığınızı hayal ediniz. Sizin için en geçerli cevabı yansıtan kutunun içine şu şekilde (X) bir çarpı işareti koyunuz. Her bir soruyu cevaplamaya çalışınız.

Seçenekler: (1) *Benim için hiç doğru değil*, (2) *Benim için birazcık doğru*, (3) *Benim için kısmen doğru*, (4) *Benim için çok doğru*, (5) *Benim için tamamen doğru*.

1. Sorunlarımı çözmeye çalışacağım yerde onlar hakkında endişelenerek çok zaman harcıyorum.
2. Çözmem gereken önemli bir sorunum olduğunda, kendimi tehdit edilmiş ve korkmuş hissederim.
3. Karar verirken, bütün seçenekleri yeterince dikkatli bir şekilde değerlendirmem.
4. Bir karar almam gerektiği zaman, kararla ilgili her bir seçeneğin diğer insanlar üzerindeki olası etkilerini göz önüne alamam.
5. Bir sorunu çözmeye çalıştığım zaman, farklı çözümleri düşünür ve daha sonra bunların bazılarını daha iyi bir çözüme ulaşmak için birleştirmeye çalışırım.
6. Önemli bir karar almam gerektiği zaman kendimi gergin hissederim ve kendimden emin olamam.
7. Bir sorunu çözmek için ilk baştaki çabalarım başarısız olduğunda, vazgeçmeyiip kolayca pes etmezsem sonunda iyi bir çözüm bulacağımın farkındayım.
8. Bir sorunu çözmeye çalışırken aklıma ilk gelen düşünceyle hareket ederim.
9. Bir sorunum olduğunda, çözülebileceğine inanırım.
10. Kendim çözmeye çalışmadan önce, bir sorunun kendiliğinden çözülüp çözülmediğini görmek için beklerim.
11. Çözmem gereken bir sorunum olduğunda yaptığım şeylerden biri, durumu incelemek ve elde etmek istediğim sonucun önünde ne tür engellerin olduğunu bulmaya çalışmaktır.
12. Bir sorunu çözmede ilk çabalarım başarısız olduğu zaman çok fazla hayal kırıklığı yaşarım.
13. Zor bir sorunla karşılaştığımda, ne kadar çok çalışırsam çalışayım kendi başıma çözebileceğimden şüphe ederim.
14. Hayatımda bir sorun ortaya çıktığında, çözmeye çalışmayı olabildiğince ertelerim.
15. Bir sorunun çözümüyle uğraşırken çözümün doğuracağı olası bütün sonuçları dikkatlice değerlendirmek için zaman harcamam.
16. Sorunlarla uğraşmaktan kaçınmak için hayatımın akışını değiştiririm.
17. Zor sorunlar beni üzer ve telaşlandırır.

18. Vermem gereken bir karar olduğunda, her seçeneğin olumlu ve olumsuz sonuçlarını tahmin etmeye çalışırım.
19. Hayatımda sorunlar ortaya çıktığında, mümkün olan en kısa süre içerisinde onları çözmek isterim.
20. Bir sorunu çözmeye çalıştığım zaman, yaratıcı olmaya ve yeni veya orijinal çözümler düşünmeye çalışırım.
21. Bir sorunu çözmeye çalıştığım zaman, aklıma gelen ilk iyi fikirle hareket ederim.
22. Bir sorun için olası farklı çözüm seçeneklerini düşünmeye çalıştığım zaman aklıma çok fazla fikir gelmez.
23. Hayatımdaki sorunları çözmek yerine onları düşünmekten uzak durmayı tercih ederim.
24. Bir karar verirken her seçeneğin hem kısa hem de uzun vadeli sonuçlarını göz önüne alırım.
25. Bir sorunu çözdükten sonra neyin doğru neyin yanlış gittiğini incelerim.
26. Bir sorunun çözümünden sonra, duygularımı gözden geçirir ve iyi yönde ne kadar değişikliklerini değerlendiririm.
27. Bir sorunu çözmeden önce, başarı şansımı arttırmak için çözümün alıştırmalarını yaparım.
28. Zor bir sorunla karşılaştığımda, yeterince gayretli çalışırsam onu tek başıma çözebileceğime inanırım.
29. Çözmem gereken bir sorun olduğunda, ilk yaptığım işlerden birisi sorun hakkında olabildiğince fazla bilgi toplamaktır.
30. Hayatımdaki sorunları çözmeyi, bıçak kemiğe dayanıncaya kadar ertelerim.
31. Sorunlardan kaçmaya onları çözmekten daha fazla zaman harcıyorum.
32. Bir sorunu çözmeye çalıştığım zaman, öylesine telaşlanıyorum ki net düşünemiyorum.
33. Bir sorunu çözmeye çalışmadan önce, tam olarak neye ulaşmak istediğimi bilebilmek için kendime bir hedef belirlerim.
34. Bir karar vermem gerektiği zaman, her bir seçeneğin olumlu ve olumsuz yönlerini düşünmek için zaman harcamam.
35. Bir sorunu çözdüğümde sonuç tatmin edici değilse, neyin yanlış gittiğini bulmaya çalışırım ve yeniden denerim.
36. Yaşamımdaki sorunları çözmek zorunda olmaktan nefret ediyorum.
37. Bir sorunu çözdüğümde, sorunla ilgili durumun olumlu yönde ne kadar değiştiğini olabildiğince dikkatli bir biçimde değerlendirmeye çalışırım.
38. Bir sorunum olduğunda, sorunu olumlu yönde faydalanılabilecek bir fırsat olarak görmeye çalışırım.
39. Bir sorunu çözmeye çalıştığım zaman, olabildiğince fazla çözüm seçeneği düşünmeye çalışırım; ta ki aklıma başka bir düşünce gelmeyinceye kadar.
40. Karar almam gerektiğinde, her bir seçeneğin sonuçlarını değerlendirip birbirleriyle karşılaştırırım.
41. Önemli bir sorunu çözmeme gerektiğinde üzüntülü, bezgin ve hareketsiz olurum.
42. Zor bir sorunla karşılaştığımda, çözmek için birilerinden yardım isterim.
43. Bir karar vereceğim zaman, her bir seçeneğin duygularım üzerindeki olası etkisini hesaba katarım.
44. Çözmem gereken bir sorunum olduğunda, çevremdeki hangi etmen ve koşulların sorunun oluşmasına katkıda bulunduğunu araştırırım.
45. Karar alırken, her seçeneğin sonuçlarını düşünmeden içimden gelen duygularla hareket ederim.

46. Karar alırken, seçenekleri değerlendirmek ve birbiriyle karşılaştırmak için sistematik bir yöntem kullanırım.
47. Bir sorunu çözmeye çalışırken, amacımın ne olduğunu sürekli aklımda tutarım.
48. Bir problemi çözmeye çalışırken, soruna olabildiğince değişik açılardan bakarım.
49. Bir problemi anlamada sıkıntıya düşersem, soruna özgü ve sorunu netleştirmeye yarayacak somut bilgiler edinmeye çalışırım.
50. Bir sorunu çözmede ilk çabalarım başarısız olursa, cesaretim kırılır ve moralim bozulur.
51. Uyguladığım bir çözüm sorunumu tatminkar bir biçimde çözmezse, neden o çözümün işe yaramadığını araştırmak için zaman harcamam.
52. Karar vermem söz konusu olduğunda çok fazla düşünmeden hareket ederim.



Appendix D: Intuitive Eating Scale-2/Sezgisel Yeme Ölçeği-2

1	2	3
Kesinlikle Katılmıyorum	Katılmıyorum	Ne Katılıyorum Ne Katılmıyorum
4		5
Katılıyorum		Kesinlikle Katılıyorum

1. Yağ, karbonhidrat ya da kalori bakımından zengin belirli yiyeceklerden kaçınmaya çalışırım.
2. Kendime yemeye izin vermediğim yasaklı yiyeceklerim vardır.
3. Sağlıksız bir şey yediğimde kendime kızarım.
4. Canım belirli bir yiyeceği çektiyse onu yemek için kendime izin veririm.
5. O an neyi yemeyi istiyorsam onu yemek için kendime izin veririm.
6. Bazı duygulara kapıldığımda (örn., kaygılı, depresif, üzgün) fiziksel olarak aç olmasam bile kendimi yemek yerken bulurum.
7. Fiziksel olarak aç olmasam da yalnız hissettiğimde kendimi yemek yerken bulurum.
8. Olumsuz duygularımı yatıştırmak için yemeği kullanırım.
9. Stresli olduğumda fiziksel olarak aç olmasam da kendimi yemek yerken bulurum.
10. Olumsuz duygularımla (örn., kaygı, üzüntü) yemeğin vereceği rahatlamaya başvurmadan da başa çıkabilirim.
11. Sıkıldığımda sadece bir meşgale olsun diye yemek yemem.
12. Yalnız hissettiğimde rahatlamak için yemek yemem.
13. Stres ve kaygıyla başa çıkmak için yemekten başka yollar bulurum.
14. Bedenimin bana ne zaman yemek yemem gerektiğini hatırlatacağına güvenirim.
15. Bedenimin beni ne yemem gerektiği konusunda yönlendireceğine güvenirim.
16. Bedenimin bana ne kadar yiyeceğimi hissettireceğine güvenirim.
17. Açlık sinyallerimin bana ne zaman yemek yemem gerektiğini hatırlatacağına güvenirim.
18. Tokluk sinyallerimin beni yemek yemeyi ne zaman durdurmam gerektiği konusunda uyaracağına güvenirim.
19. Bedenimin bana yemek yemeyi ne zaman durdurmam gerektiğini hatırlatacağına güvenirim.
20. Çoğunlukla bedenimin daha iyi bir performans göstermesini sağlayacak yiyecekler yerim.
21. Çoğunlukla bedenime enerji ve dayanıklılık sağlayacak yiyecekler yerim.

Appendix E: Turkish Emotional Eating Scale/Türkçe Duygusal Yeme Ölçeği

Aşağıda yaşamınızla ilgili bazı ifadeler bulunmaktadır. Herhangi teşhisi konmuş Bulimiya Nervoza, Anoreksiya Nervoza veya Tikanırcasına Yeme Bozukluğu'nuz yok ise size uygunluk derecesine göre (asla, nadiren, bazen, sıklıkla, neredeyse her zaman) seçeneklerinden bir tanesini işaretleyiniz.

1. Zor zamanlarda, sağlıksız davranışlara daha eğilimli oluyorum.
2. Kendimi baskı altında hissedersen daha çok yerim.
3. Stresli olduğum zamanlarda daha çok yerim.
4. Kendimi çaresiz hissedersen yemek yemek isterim.
5. İş tempom yoğunlaşırsa daha çok yerim.
6. Yemeği abarttığımda suçlu hissedirim.
7. Yiyecekleri, ödül ve zevk kaynağı olarak kullanırım.
8. Aç olmadığımda yerim.
9. Bir şeyler beklediğim gibi gitmezse yemek yemek isterim.
10. Bir şeylerden rahatsız olduğumda daha fazla yemek isterim.
11. Bir konuda depresif ya da üzgünsem yemek yemek isterim.
12. Bir konuda endişeli ya da kaygılı hissediyorsam yemek yemek isterim.
13. Canımın sıkkın olduğu zamanlarda yemek yemek isterim.
14. Yalnız hissettiğimde yemek yemek isterim.
15. Biri beni üzdüğünde yemek yemek isterim.
16. Bana acı veren bir deneyimimi hatırlatan benzer durumlarda yemek yemek isterim.
17. Korktuğum zaman yemek yemek isterim.
18. Sinirlerimin bozuk olduğu zamanlarda yemek yemek isterim.
19. Yaptığım bir şeyden dolayı kötü ya da suçlu hissedersen yemek yemek isterim.
20. Kendimi incinmiş hissedersen yemek yemek isterim.
21. Heyecanlı olduğum zamanlarda yemek yemek isterim.
22. Sorunlarımla baş edebilmek için yemek yerim.
23. Yememin kontrolümün dışında olduğunu hissediyorum.
24. Lezzetli bir şey görüp kokusunu alırsam onu yemek isterim.
25. Başkalarını yemek yerken görürsem ben de yemek yemek isterim.
26. Diyet söz konusu olduğunda irademe hakimim.
27. Kilo kontrolünde diyetle istikrarı sağlayamıyorum.
28. Lezzetli yiyeceklere karşı koyabilirim.
29. Yemek için ısrar edilirse hayır diyebilirim.
30. Yiyecekler duygularıyla baş etmede bana yardım ediyor.

Appendix F: Eating Disorder Examination Questionnaire (EDE – Q – 13)

Short Form/Yeme Bozukluğu Değerlendirme Ölçeği-13 (EDE – Q – 13)

Kısa Form

Aşağıdaki sorular sadece son dört hafta (28 gün) ile ilgilidir. Lütfen her soruyu dikkatlice okuyunuz. **Aşağıdaki ifadeleri son 28 günün kaç gününde deneyimlediyseniz o kadar gün sayısını işaretleyiniz.** Lütfen tüm soruları yanıtlayınız ve her soru için bir yanıt seçiniz. Teşekkür ederiz.

Seçenekler: (1) 0, (2) 1-5, (3) 6-12, (4) 13-15, (5) 16-22, (6) 23-27, (7) Her gün.

Son 28 günün kaç gününde...

1. bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için yediğiniz yiyecek miktarını kasıtlı olarak sınırlandırmaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)
2. bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için sevdiğiniz herhangi bir yiyeceği beslenme düzeninizden çıkarmaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)
3. bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için yemenizle ilgili belirli kurallara (örneğin, kalori sınırlandırması) uymaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)
4. vücut ağırlığınız, kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi?
5. bedeninizin şekli, kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi?
6. vücut ağırlığınızdan memnun değildiniz?
7. bedeninizin şeklinden memnun değildiniz?
8. başka insanların alışılmadık miktarda fazla olarak tanımladıkları kadar (şartlara göre) yemek yediniz?
9. yemek yemenizle ilgili kontrolü kaybetme hissine kapıldınız (yemek yediğiniz sırada)?
10. aşırı yeme atakları yaşadınız (örn. alışılmadık miktarda fazla yemek yediniz ve o sırada kontrolü kaybettiğinizi hissettiniz)?
11. bedenizin şeklini veya vücut ağırlığınızı kontrol etmek için kendinizi kusturdunuz?
12. bedeninizin şeklini veya vücut ağırlığınızı kontrol etmek için müshil (bağırsak çalıştırıcı) kullandınız?
13. vücut ağırlığınızı, bedeninizin şeklini veya vücut yağ miktarınızı kontrol etmek veya kalori yakmak amacıyla “takıntılı” ya da “zorlayıcı” biçimde egzersiz yaptınız?