DEPARTMENT OF PSYCHOLOGY

AN EXAMINATION OF THE RELATIONSHIP BETWEEN CHILDHOOD PEER VICTIMIZATION AND DISORDERED EATING IN EMERGING ADULTS: A MIXED METHOD APPROACH

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Maria P. Markou

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ABSTRACT IN GREEK

Σύμφωνα με προηγούμενες έρευνες, ο σχολικός εκφοβισμός στην παιδική ηλικία (ΣΕΠΗ) αποτελεί ένα από τους σημαντικότερους παράγοντες κινδύνου για την ανάπτυξη διατροφικών διαταραχών και υπό-κλινικών συμπτωμάτων των διατροφικών διαταραχών, όπως τις διαταραγμένες διατροφικές συμπεριφορές (ΔΔΣ). Ωστόσο, παρά τα εμπειρικά ευρήματα που υποδεικνύουν τις ΔΔΣ ως πιθανό αποτέλεσμα του ΣΕΠΗ, σημαντικά ερωτήματα παραμένουν ιδιαίτερα όσον αφορά τους μηχανισμούς που εμπλέκονται στην ανάπτυξη ΔΔΣ κατά την αναδυόμενη ενηλικίωση. Τα υψηλά ποσοστά ΔΔΣ στην αναδυόμενη ενηλικίωση και οι αρνητικές σωματικές και ψυχολογικές επιπτώσεις που έχουν συσχετιστεί με τις ΔΔΣ υπογραμμίζουν την ανάγκη για έγκαιρο εντοπισμό και στοχευμένων παρεμβάσεων για τον συγκεκριμένο πληθυσμό.

Προβλήματα στην ανάπτυξη της ταυτότητας, καθώς και οι δυσκολίες στην ρύθμιση συναισθημάτων έχουν επανειλημμένα συσχετιστεί με την ανάπτυξη ΔΔΣ στην βιβλιογραφία. Ως εκ τούτου, η παρούσα έρευνα εφαρμόζει την μέθοδο μικτής προσέγγισης για να εξετάσει πως αυτοί οι παράγοντες συμβάλλουν στη σχέση μεταξύ των αρνητικών επιπτώσεων του ΣΕΠΗ και της ανάπτυξης ΔΔΣ στην αναδυόμενη ενηλικίωση. Συγκεκριμένα, η έμμεση σχέση μεταξύ των αρνητικών επιπτώσεων του ΣΕΠΗ και της ανάπτυξης ΔΔΣ μέσω της παθολογικής ταυτότητας, καθώς και ο ρυθμιστικός ρόλος της δυσκολίας ρύθμισης συναισθημάτων στην σχέση μεταξύ ΣΕΠΗ και ΔΔΣ εξετάστηκαν στην ποσοτική φάση, ενώ η ποιοτική φάση εξέτασε πως οι αναδυόμενοι ενήλικες που έχουν υποστεί ΣΕΠΗ βιώνουν και ερμηνεύουν τις ΔΔΣ.

Κατά την διάρκεια της ποσοτικής φάσης, χορηγήθηκαν διαδικτυακά ερωτηματολόγια σε 414 αναδυόμενους ενήλικες. Οι υποθέσεις εξετάστηκαν χρησιμοποιώντας Μοντέλα Δομικών Εξισώσεων. Τα αποτελέσματα από την ποσοτική φάση υποδεικνύουν ότι οι αρνητικές επιπτώσεις του ΣΕΠΗ προβλέπουν την ανάπτυξη ΔΔΣ στην αναδυόμενη ενηλικίωση. Επίσης, η έμμεση σχέση μεταξύ των αρνητικών επιπτώσεων του ΣΕΠΗ και της

ανάπτυξης της υπερφαγίας στην αναδυόμενη ενηλικίωση μέσω της παθολογικής ανάπτυξης της ταυτότητας υποστηρίχθηκε, τονίζοντας τον σημαντικό ρόλο της ταυτότητας στην αναδυόμενη ενηλικίωση. Ωστόσο, ο ρυθμιστικός ρόλος της δυσκολίας στην ρύθμιση συναισθημάτων στην σχέση ΣΕΠΗ και ΔΔΣ δεν υποστηρίχθηκε.

Η ποιοτική φάση επικεντρώθηκε στην εξέταση της εμπειρίας ΔΔΣ σε αναδυόμενους ενήλικες που έχουν υποστεί ΣΕΠΗ, χρησιμοποιώντας ημιδομημένες συνεντεύξεις. Το δείγμα της δεύτερης φάσης αποτελείτο από έξι άτομα τα οποία επιλέγηκαν με βάση το σκορ τους στα ερωτηματολόγια των ΔΔΣ της πρώτης φάσης. Η ανάλυση των συνεντεύξεων έγινε με βάση την Ερμηνευτική Φαινομενολογική Ανάλυση. Δυο κύριες κατηγορίες προέκυψαν από την ανάλυση: 1) Αιτίες και παράγοντες που πυροδοτούν τις ΔΔΣ, 2) Λειτουργίες και μηχανισμοί συντήρησης των ΔΔΣ. Τα αποτελέσματα από την ποιοτική φάση υποδεικνύουν ότι οι αναδυόμενοι ενήλικες που έχουν υποστεί ΣΕΠΗ ερμηνεύουν τις ΔΔΣ με βάση τον τρόπο που αναπτύχθηκαν και πυροδοτούνται, καθώς και με βάση του πως συντηρούνται. Κυριότερα, διαπιστώθηκε ότι οι συμμετέχοντες βιώνουν τις ΔΔΣ τους ως αποτέλεσμα της εμπειρίας που είχαν με τον ΣΕΠΗ. Τα αποτελέσματα από την ποιοτική φάση της έρευνας παρέχουν επιπλέον υποστήριξη για τα αποτελέσματα της ποσοτικής φάσης και περαιτέρω πληροφορίες σχετικά με τους μηχανισμούς ανάπτυξης και συντήρησης των ΔΔΣ σε αναδυόμενους ενήλικες που βίωσαν ΣΕΠΗ.

Συνολικά, η παρούσα έρευνα παρέχει προκαταρκτικά ευρήματα τα οποία υπογραμμίζουν το ρόλο του ΣΕΠΗ και της ταυτότητας στην ανάπτυξη ΔΔΣ στην αναδυόμενη ενηλικίωση, όπως επίσης και περαιτέρω πληροφορίες σχετικά με το πως οι αναδυόμενοι ενήλικες που έχουν υποστεί ΣΕΠΗ βιώνουν τις ΔΔΣ.

ABSTRACT

Childhood peer victimization (CPV) is a well-known risk factor for the development of clinical and subclinical forms of eating disorders, including disordered eating behaviours (DEBs). Despite the empirical evidence suggesting DEBs to be among the potential negative outcomes associated with CPV, important questions still remain, particularly as to the mechanisms involved in the development of DEBs once individuals enter emerging adulthood. Given the high prevalence of DEBs in emerging adulthood and the potential severe physical and psychological consequences associated with DEBs, there is a growing need for early detection and the development of targeted interventions for this population.

Impairments in identity development have been repeatedly related to DEBs. Similarly, difficulties in emotion regulation have shown to play an important role in the development and maintenance of DEBs. The present thesis uses a cross-sectional mixed-method design to examine how these factors contribute to the relationship between the harmfulness of the CPV experience and the development of DEBs in emerging adulthood. Specifically, the indirect relationship between CPV harmfulness and DEBs through pathological identity development, as well as the moderating role of difficulties in emotion regulation in the relationship between CPV harmfulness and DEBs were examined during the quantitative phase, whilst the qualitative phase examined how emerging adults with a history of CPV interpret their experiences with DEBs.

For the quantitative phase, 414 emerging adults completed an online questionnaire assessing CPV, DEBs (restriction and binge-eating), identity development and difficulties in emotion regulation. Data were analysed using Structural Equation Modelling. The results indicated significant direct effects of CPV harmfulness on both restrictive and binge-eating behaviours. More importantly, findings supported the indirect relationship between CPV harmfulness and binge-eating through pathological identity development. However, the

moderation analysis did not support the moderating role of difficulties in emotion regulation in the relationship between CPV harmfulness and DEBs.

The qualitative phase focused on examining how emerging adults with a history of CPV interpret their experiences with DEBs. A subset of participants from the sample of phase one was selected for the qualitative phase. In total, six participants who scored a specific threshold on either measure of the DEBs were interviewed. The resulting transcripts were then analysed using Interpretative Phenomenological Analysis. Two overarching themes were identified: 1) Causes and triggers for DEBs and 2) Functions and maintaining mechanisms of DEBs. The key idea from the qualitative findings is that participants experience and understand their DEBs in terms of how they developed and are triggered, and in terms of how they persist. Most importantly, their accounts suggest that they understand their DEBs as a response to CPV experiences. The findings from the qualitative phase provide additional support for the quantitative results and further insights into the mechanisms of the development and maintenance of DEBs in emerging adults with a history of CPV.

The present thesis provides preliminary findings that highlight the role of CPV and identity development in the development of DEBs in emerging adulthood, and further understanding into how emerging adults with CPV history interpret their experiences with DEBs.

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Chapter One: Introduction

Eating disorders (EDs) are increasingly recognized as a serious worldwide public health concern, especially for young adults. A significant amount of research has been conducted over the years in an attempt to better understand the processes involved in the development of EDs. Despite advancements in this area, the etiology remains unclear. Several individual risk factors have been proposed including perfectionism (Locker, Heesacher, & Baker, 2012); low self-esteem (Polivy & Herman, 2002); body dissatisfaction (Lavender & Anderson, 2010); emotion dysregulation (Lavender et al., 2015); identity problems (e.g., Bruch, 1982; Polivy, Herman, & McFarlane, 1994; Verschueren et al., 2018); and interpersonal trauma including peer victimization (Copeland, Bulik, Zucker, Wolke, Lereya, & Costello, 2015). These in addition to other factors interact in complex ways that can lead to the development of eating pathology.

Childhood peer victimization (CPV) is considered to be among the risk factors for the development of eating pathology (e.g., Copeland, Bulik, Zucker, Wolke, Lereya, & Costello, 2015). Traditionally, bullying has been defined as an "aggressive behaviour or intentional harm doing, which is carried out repeatedly and over time in an interpersonal relationship characterized by an imbalance of power" (Olweus, 1993, pp. 8–9). While this definition has been central in instigating research on the topic of bullying, recent empirical evidence has led to some criticism of this definition (e.g., Liu & Graves, 2011). In face of this criticism, Volk, Dane, and Marini (2014) proposed a newer definition of bullying: "bullying is aggressive goal-directed behaviour that harms another individual within the context of a power imbalance", emphasizing the concepts of power, harm and goal-directedness (Volk, Dane, & Marini, 2014). The concept of *harm* from this definition is central to the present thesis and is referred to as "CPV harmfulness" throughout the thesis. While the literature suggests an

association between CPV and eating pathology (e.g., Frank & Acle, 2014; Engstrom & Norring, 2002; Haines et al., 2006; Striegel-Moore et al., 2002), to our knowledge, no previous study has used the concept of *harmfulness* when examining this relationship.

Another factor that has been incorporated in many theoretical accounts of EDs and is considered among the key contributors to the development of eating pathology is emotion dysregulation (e.g., Bruch, 1973; Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman, 1985). Emotion dysregulation is defined as a difficulty in one's ability to identify, understand, successfully control and cope with negative emotions (Gratz & Roemer, 2004). Research in this area highlights the occurrence of disordered eating as a response to negative emotions and support the idea that disordered eating functions as a pathological means that helps cope with negative emotion (e.g., Heatherton & Baumeister, 1991; Herman & Polivy, 1988; Polivy, Herman, & McFarlane, 1994).

A number of researchers over the years have also identified pathological identity development to be an important factor that is associated with the development of EDs and most of them assume identity problems to precede eating pathology (e.g., Bruch, 1982; Gonidakis et al., 2018; Verschueren et al., 2018). Briefly, it has been suggested that ED symptomatology may originate from a lack of a clear definition of the self (i.e., identity diffusion) that makes individuals more vulnerable to implement maladaptive search processes (i.e., disordered eating behaviours) as a way to adopt a clearer sense of identity (Bruch, 1981, 1982). Previous research examining the concept of identity development in relation to eating pathology has used measures that are based on a phenotypical structure and are either too much focused on pathological identity development, disregarding normal variants of identity, or on healthy identity development, disregarding pathological identity development (Goth et al., 2012). Identity, however, is a highly complex psychological construct that involves social, cognitive and pathology related qualities, and therefore it is important to examine identity

development using a scale that measures both healthy and disturbed identity development. Goth and colleagues developed the Assessment of Identity Development in Adolescence self-report questionnaire (AIDA; Goth et al., 2012) in an effort to assess pathology-related identity development. The present thesis uses the AIDA questionnaire (Goth et al., 2012) as a measure for identity development. Although there is some research on the relationship between identity and eating pathology, no single study exists that uses the AIDA measure in the context of CPV and eating pathology.

Statement of the Problem

Childhood peer victimization, identity development, emotion regulation and their relationship with eating pathology has been examined to some extent. However, the research to date has tended to focus on individuals with diagnosable eating disorders instead of subclinical forms of EDs (i.e., disordered eating behaviours; DEBs). This is an important issue given the high prevalence rate of subclinical forms of EDs in the general population (e.g., Ricciardelli & Yager, 2015). In addition, as with diagnosable eating disorders, DEBs have also been associated with serious physical and psychological consequences (e.g., Fairburn, 2008). More concerning is the fact that many individuals struggling with disordered eating may not seek help because of the shame and secrecy that accompany these disorders (e.g., Hackler, Vogel, & Wade, 2010). Given this information and the potential severe consequences associated with DEBs, there is a growing need for early interventions that target prevention in EDs. Accordingly, focusing on identifying specific risk and protective factors that influence the development of DEBs is crucial as these behaviours often precede the development of clinical diagnosable EDs (e.g., Torstveit, Rosenvinge, & Sundgot-Borgen, 2008).

The central aim of this thesis is to examine the effect of CPV in the development of DEBs in emerging adulthood and how pathological identity development and the use of maladaptive emotion regulation strategies contribute to this relationship. More specifically, the

harmfulness of the CPV experience was examined as a risk factor for the development of DEBs in emerging adulthood. While there is some literature for the relationship between CPV and the development of eating pathology (e.g., Frank & Acle, 2014; Engstrom & Norring, 2002; Haines et al., 2006; Striegel-Moore et al., 2002), research on this subject has been mostly restricted in the operationalization of peer victimization based on the frequency that bullying incidence occur, with many measures considering repeated exposure to bullying incidents in order to classify them as bullying (e.g., Solberg & Olweus, 2003). The problem is that one single bullying incident can be as harmful as incidents that occur repeatedly over time (Olweus, 2013). Because CPV experiences can result in numerous negative effects on the psychological functioning and adjustment of the victim (e.g., Takizawa, Maughan, & Arseneault, 2014), there is a need to investigate the effect of the whole range of bullying experiences, including the less frequent but high in intensity incidents that can be harmful to the victim. Therefore, the present thesis focuses on measuring the harmfulness from the CPV experience rather than the frequency and perceived intensity separately. A greater focus on the harmfulness of the CPV experiences could produce interesting findings that account more for the association between CPV and DEBs in emerging adults.

In addition, most studies in eating pathology have been restricted to adult samples. However, this thesis focuses on *emerging adulthood* that is a distinct life period between the ages of 18-25 (Arnett, 2000, 2007). The typical onset of eating disorders is usually during emerging adulthood (Steinhausen & Jensen, 2015), and DEBs seem to be prevalent during this period (Liechty & Lee, 2013). During emerging adulthood, individuals are faced with numerous changes in their life domains (Arnett, 2000), that can create a sense of uncertainty and pressure to the individual resulting in mental health problems (e.g., Schulenberg, Sameroff, & Cicchetti, 2004). Emerging adulthood is therefore of particular interest to the

present thesis as there may be implications for treatment and prevention programs that are unique to this group.

Finally, few studies have used a combination of both quantitative and qualitative approaches to investigate DEBs in emerging adults; even less so in those who have experienced CPV. While there are some qualitative studies reporting on how individuals experience EDs (e.g., Fox, Larkin, & Leung, 2011; Nordbo, Espeset, Gulliksen, Skarderud, & Holte, 2006), little is known about how emerging adults who also have a history of CPV experience DEBs and how they make sense of the CPV experience in relation to their current DEBs, providing rationale for the qualitative phase of the current thesis. Increasing knowledge, understanding and awareness surrounding emerging adults' unique meanings attributed to their experiences with DEBs could not only complement the quantitative results of the present thesis but also provide insight into the mechanisms of the development and maintenance of DEBs in emerging adults with a history of CPV. The present thesis, therefore, uses an exploratory mixed-method design to explore the complex relationship between CPV and DEBs in emerging adults.

Chapter Two: Literature Review

Eating Pathology

Eating disorders are marked by a persistent disturbance in eating behaviours that result in physical and psychological impairments. Anorexia nervosa (AN), Bulimia Nervosa (BN) and Binge-Eating Disorder (BED) are three primary diagnoses under the Feeding and Eating Disorders section of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychological Association, 2013). Anorexia nervosa (AN) is characterised by severe restriction of food intake, which leads to a significant low body weight. It is also characterized by an intense fear of gaining weight or becoming fat, and a disturbance in the way body shape and weight are experienced. Bulimia nervosa (BN) is characterised by repeated episodes of binge-eating and recurrent inappropriate compensatory behaviours in order to prevent weight gain. Binge-Eating Disorder (BED), which is a new diagnosis added in the DSM-5 (American Psychological Association, 2013), is described by repeated episodes of eating large quantities of food, usually in a short period of time, accompanied by a feeling of loss of control during the binge and feelings of shame, distress or guilt after the binge. In addition to AN, BN and BED, there are five additional eating disorder diagnostic categories. These include a) Pica, b) Rumination disorder, c) Avoidant/Restrictive Food Intake Disorder, d) Other Specified Feeding or Eating Disorder and e) Unspecified Feeding or Eating Disorder (DSM-5; American Psychiatric Association, 2013).

The lifetime prevalence of AN, BN and BED in the general population is estimated to be 0.21%, 0.81% and 2.22% respectively (Qian et al., 2013). Despite the relatively low prevalence rates of ED diagnoses, subclinical forms of EDs (i.e., disordered eating behaviours; DEBs) that do not meet the formal diagnostic criteria of EDs are very common, with prevalence rates ranging from 4% to 16% in the general population (e.g., Ricciardelli & Yager, 2015).

Disordered Eating Behaviours (DEBs) include a wide range of abnormal eating behaviours (e.g., restriction of food, overeating, binge-eating, unhealthy dieting, using different means to control weight) many of which are shared with the diagnoses of EDs (DSM-5; American Psychiatric Association, 2013). However, what differentiates subclinical forms of EDs from diagnosed EDs is the frequency that they are carried out and the level of severity. Considering the heterogeneity of disordered eating symptoms, it's helpful to consider each symptom separately instead of grouping them all in one. Behaviours that are especially relevant for the present thesis include restrictive eating and binge-eating behaviours. Restrictive eating consists of behaviours such as severely restricting food intake, frequent meal skipping and fasting. Binge-eating involves eating a larger amount of food than most people would eat in a discrete period of time with a sense of lack of control over eating during that time (DSM-5; American Psychiatric Association, 2013).

Even if DEBs alone are considered subclinical forms of EDs, their presence is still of high concern as they are considered to be a strong risk factors for more severe eating pathology, including a future diagnosis of EDs (e.g., Torstveit, Rosenvinge, & Sundgot-Borgen, 2008). Disordered eating behaviours have also been associated with adverse physical (i.e., difficulties concentrating, poor sleep and low energy, affecting the individual's ability to participate fully in educational and professional contexts) and psychological consequences (i.e., difficulty concentrating due to preoccupation with food and social withdrawal) (e.g., Fairburn, 2008). Given the potential severe consequences associated with EDs interventions that target prevention in EDs are essential since patients with an ED are very often resistant to treatment and high drop-out and relapse rates are common (Fairburn & Harrison, 2003). Moreover, shame and secrecy often accompany these disorders and thus individuals with eating pathology are less likely to seek help (e.g., Hackler, 2010). Accordingly, focusing on identifying specific risk and protective factors that influence the development of DEBs is

crucial as these behaviours often precede the development of ED diagnoses (e.g., Torstveit, Rosenvinge, & Sundgot-Borgen, 2008).

Childhood Peer Victimization

In recent years, there has been an increasing interest in the role of bullying in the development of eating pathology (e.g., Copeland, Bulik, Zucker, Wolke, Lereya, & Costello, 2015). According to Olweus (1993), bullying is a chronic form of victimization that involves repeated hurtful actions towards the other person and happens between peers. Building on Olweus's definition of bullying, researchers investigating bullying behaviours describe bullying according to the following characteristics: (1) bullying behaviour is directed towards the victim with the intention to harm or instil fear in the victim, (2) the behaviour occurs repeatedly over a period of time, (3) occurs within the context of a social group, and (4) an imbalance of power between the predator and the victim exists (Greene, 2000; Griffin & Gross, 2004; Hawker & Boulton, 2000; Roth, Coles, & Heimburg, 2002; Olweus, 1993; Tritt & Duncan, 1997). Bullying can take different forms such as, physical bullying (e.g., hitting), verbal bullying (e.g., calling names) and relational (e.g., spreading rumours, exclusion and rejection from social groups) (Griffin & Gross, 2004).

While Olweus's definition of bullying has been central in the bullying research, recent empirical evidence has led to some criticism of this definition (e.g., Liu & Graves, 2011). In response to this criticism, Volk, Dane, and Marini (2014) proposed a newer definition of bullying: "bullying is aggressive goal-directed behaviour that harms another individual within the context of a power imbalance", emphasizing the concepts of power, harm and goal-directedness (Volk, Dane, & Marini, 2014). Central to the present thesis is the concept of *harm* in the definition offered by Volk and colleagues (2014).

Harm is conceptualized as the product of both the frequency and the perceived intensity of the bullying experience (Volk, Dane, & Marini, 2014). In their review, Volk and

colleagues (2014) discuss the importance of measuring the harmfulness from the bullying experience instead of the frequency and perceived intensity separately as a way to capture the whole range of bullying behaviours, including the less frequent but high in intensity incidents that can be harmful to the victim. This proposition rests on literature indicating that single bullying incidence can be as harmful as bullying incidence that are repeated over time (e.g., DeHue, Bolman, & Völlink, 2008; Olweus, 2013). To our knowledge, no previous study used the concept of *harmfulness* when examining the relationship between CPV retrospective reports and DEBs.

Childhood is considered the most critical stage of psychological development (e.g., Elder, 1998) and theorists argue that negative experiences during this developmental period, including any form of traumatic experience, tends to increase individuals' risk for mental health disorders in adulthood (e.g., Duncan, Saunders, Kilpatrick, Hanson, & Resnick, 1996; Jeronimus, Ormel, Aleman, Penninx & Riese 2013; Macmillan, 2001; Nurius, Green, Logan-Greene, & Borja, 2015). The profound impact of childhood traumatic experiences on adult mental health has been highlighted in studies indicating negative consequences on adults' mental health resulting from events that occurred only in childhood that were not repeated in adolescence or adulthood (Benjet, Borges, & Medina-Mora, 2010). It therefore follows that traumatic experiences, including the experience of being bullied during childhood, can have particularly detrimental effects in individuals' later life.

Indeed, consistent evidence over the years has demonstrated that CPV is associated with numerous negative effects on the psychological functioning and adjustment of the victim at the time of victimization and several years later (e.g., Takizawa, Maughan, & Arseneault, 2014). Retrospective studies on college students who have reported being victims of bullying during childhood and adolescents, for instance, have demonstrated that these individuals are at a greater risk for developing mental health difficulties, including anxiety, depression and

problems in interpersonal relationships (e.g., McCabe, Miller, Laugesen, Antony, & Young, 2010; Newman, Holden, & Delville, 2005; Storch et al., 2004). In support of this, a meta-analysis by Ttofi and colleagues (2011) showed that victims were more likely to have depression up to 36 years after experiencing bullying (Ttofi, Farrington, Lösel, & Loeber, 2011).

Childhood Peer Victimization and Disordered Eating Behaviours

Among the common negative consequences of CPV are EDs (e.g., Copeland, Bulik, Zucker, Wolke, Lereya, & Costello, 2015). Engstrom and Norring (2002), using a retrospective design, indicated that women with DEBs were more likely to report being bullied during childhood. Likewise, Striegel-Moore and colleagues (2002) showed that women who reported being bullied by peers in childhood were more likely to report binge-eating in adulthood. Frank and Acle (2014) also found that 92% of the participants who had a diagnosis of an ED reported that they have experienced peer victimization during their childhood as well.

Few studies have examined the prospective association between CPV experiences and DEBs and the results from such studies are mixed. For instance, Haines and colleagues (2006) indicated that weight-related teasing predicted the development of DEBs in adolescence five years later. Similarly, reports about weight and shape teasing by peers predicted later increases in bulimic behaviours in adolescent girls (Wertheim, Koerner, &Paxton, 2001) and binge-eating behaviour among girls and boys (Agras, Bryson, Hammer, & Kraemer, 2007). In contrast, other studies utilizing prospective designs found that CPV was not prospectively associated with DEBs and suggest that the relationship between the experience of peer victimization and DEBs is only present at the time of victimization (e.g., Copeland et al., 2015).

Despite the evidence reviewed above suggesting DEBs to be among the potential negative outcomes associated with CPV, important questions still remain particularly with regards to the mechanisms involved in the development of DEBs once individuals enter emerging adulthood. Previous research has focused on different self-cognitions as mediators in the relationship between peer victimization and mental health outcomes (e.g., Hawker & Boulton, 2000; Troop-Gordon & Ladd, 2005). The present thesis examines the role of pathological identity development in the relationship between CPV and DEBs as it is considered more relevant during emerging adulthood where identity formation is a central task (Arnett, 2002).

Identity Development

According to Erikson (1968) and Arnett (2000), a core developmental task that individuals are faced with during adolescence and emerging adulthood is the task of identity development. Erikson (1950, 1968) was the first to formulate the concept of identity. According to Erikson (1968), both identity synthesis and confusion define one's identity structure. Identity synthesis reflects a consolidated and coherent sense of identity and refers to an individual's ability to retain internal consistent set of values, goals and beliefs over time and across contexts (Erikson, 1968). Individuals that score high on identity synthesis experience a sense of self-continuity over time and across contexts (Erikson, 1968). Identity confusion, on the other hand, indicates lack of self-knowledge and a failure to form an integrated concept of self (Erikson, 1968; Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001). This lack of integration of the concept of self can have a major impact on how an individual views the world and may include negative consequences, such as loss of capacity to commit to values and goals, as well as to relationships that may lead to further negative consequences in the individuals' lives (Kernberg & Caligor, 2005). Provided that identity synthesis prevails identity confusion, they can both be adaptable to some degree (Erikson, 1950).

Building on Erikson's theory, Marcia (1966, 1980) proposed the identity status paradigm in which individuals can be categorised in one of four different identity statuses: *Achievement, Moratorium*, *Foreclosure* and *Diffusion.* Identity diffusion results when an individual does not form a consolidated identity and is considered to be a part of normal development in most of the theories discussed above (i.e., Marcia, 1966). During the last two decades many authors have proposed different models that expand on Marcia's model (1966, 1980), such as the 'Dual-cycle model' by Luyckx and colleagues (2008).

In contrast to the non-pathological view of identity diffusion mentioned above, other authors view identity diffusion as signifying an underlying pathological condition (e.g., Kernberg & Caligor, 2005; Lenzenweger et al., 2001). According to Kernberg (1986), identity development lies on a continuum, with identity diffusion at one end and integrated identity on the other end (Kernberg, 1986). Identity diffusion, according to Kernberg (1985), can manifest to difficulties in impulse control, poor anxiety tolerance, and feelings of chronic emptiness.

Based on an integrated understanding of healthy and pathological identity development, Goth and colleagues developed the Assessment of Identity Development in Adolescence self-report questionnaire (AIDA; Goth et al., 2012) in an effort to assess pathology-related identity development. The AIDA model distinguishes between two domains: "Continuity" and "Coherence" that serve as substructures to the higher order construct of "Identity integration" and "Identity diffusion". The two scales are coded towards psychopathology and are therefore named "Discontinuity" and "Incoherence". High scores on the "Discontinuity" and "Incoherence" scales indicate identity diffusion.

The construct of *Continuity* refers to the "emotional self-sameness with an inner stable timeline" (Goth et al., 2012). Example items from the questionnaire illustrating the *Discontinuity* construct include: "I feel I don't really belong anywhere; I often don't know how I feel right now". An individual who scores low on this construct will have stable

identity-related values, goals, relationships and access to emotions that will enable him/her to function autonomously. A high score, however, indicates discontinuity, which is associated with no sense of belonging. The construct of *Coherence* refers to the sense of clarity of self-definition based on self-reflective awareness (Goth et al., 2012). A lack of identity *Coherence* (i.e., *Incoherence*) is associated with having poor access to cognitions and motives and being suggestible and ambivalent (Goth et al., 2012). Example items from the questionnaire illustrating the *Incoherence* construct include: "I often feel lost, as if I had no clear inner self; I am confused about what kind of person I really am".

The present thesis is based on the understanding of identity development offered by Goth and colleagues (2012) and therefore uses the AIDA to assess identity development in the sample.

Identity Development and Disordered Eating Behaviours

The idea that identity disturbances are associated with EDs has been around for many years. Most researchers agree that identity problems precede EDs. For instance, Bruch (1978), who defined AN as a "struggle for control, for a sense of identity, competence, and effectiveness" (pp. 251), suggested that impairments in identity development can influence the development of AN (Bruch, 1982). She argued that individuals who do not have a clear sense of identity turn to body weight, a culturally valued and easily controlled domain, as a source to evaluate one's self and thus as a source for self-definition (Bruch, 1998). Disordered eating behaviours, which provide clear and objective criteria on which to evaluate self are therefore adopted by vulnerable individuals (McFarlane et al., 2001). From this perspective, individuals fixate on body weight and exhibit DEBs as a means to compensate and cope with the lack of a clear identity (Bruch, 1981, 1982).

Others examining the association between identity disturbance and DEBs focused on the functional mechanism of DEBs (e.g., Heatherton and Baumeister, 1991; Herman and

Polivy, 1988; Polivy, Herman, & McFarlane, 1994). In Heatherton and Baumeister's *escape theory* (1991), binge-eating is viewed as a way to "escape" from the distress associate with self-awareness and negative thoughts about one's identity through the process of *mental narrowing* that shifts attention away from the self and onto stimuli in the environment (i.e., food). The process of mental narrowing helps individuals avoid negative thoughts about self and focus on something pleasurable, such as food, resulting in binge-eating behaviour. Binge-eating is maintained as it helps decrease the emotional distress that is related to the individual's sense of self (Heatherton & Baumeister, 1991).

There have been a number of empirical studies supporting the notion that identity problems precede eating symptomatology. Vartanian (2009), for instance, indicated that identity confusion predicted internalization of societal standards about weight and appearance that in turn predicted the development of eating symptomatology in women. Additionally, high levels of unstable perceptions of self were found to predict DEBs in adolescent girls (Kansi, Wichstrpm, and Bergman, 2003). More recently, a cross-sectional study by Gonidakis and colleagues (2018), indicated that the distinctive developmental tasks specific to emerging adulthood, including identity exploration, were associated with DEBs in emerging adulthood (i.e., unhealthy dieting, binge-eating, purging) (Gonidakis et al., 2018).

Recently, there has been an increasing interest in the reciprocal relationship between identity development and eating symptomatology. As summarised in Verschueren and colleagues' (2020) review, identity diffusion can make someone more vulnerable to internalize societal standards in regard to the perfect body ideal that in turn can be used as a source of self-definition. This may promote the desire to be thin and elicit DEBs. Body image thus becomes central to one's identity and as a result, gaining weight could be considered as a threat to one's identity. This contributes to the development of a susceptible sense of self and hence identity diffusion.

In line with the above, Verschueren and colleagues (2018) examined the bidirectional relationship between identity development and eating symptomatology using longitudinal data and their findings support the idea of bidirectionality. More specifically, their findings indicated that identity confusion predicted bulimic symptoms over time and that bulimic symptoms predicted increases in identity confusion, supporting the notion that eating symptomatology can also affect identity development. Similarly, Schupak-Neuberg and Nemeroff (1993), in their study using a sample of individuals with symptoms of BN, reported that those individuals exhibited less stability in their definitions of self and greater confusion concerning their identity compared to a control group. They described that binge and purge in these individuals served as a coping strategy, helping them regulate their identity.

Identity Development and Childhood Peer Victimization

Erikson (1968) emphasised the need for an average and predictable environment for the development of a stable identity. Incidents, such as peer victimization are extremely stressful experiences, especially during childhood and adolescence (Somerville, 2013) and, like traumatic events, have the potential to disrupt the life of the individual. These incidents cannot only affect the internal cohesion and sense of continuity of the victims but can also contribute to the inability to function in social environments that can further affect identity development. Moreover, it has been suggested that spending time with peers is crucial for identity development as peers can offer a context that can enhance the exploration of different norms and values and thus allow individuals to understand themselves better and develop their own beliefs and values (Laible, Carlo, & Raffaelli, 2000; Nawaz, 2011). Accordingly, being excluded from peer groups can influence the process of developing a coherent sense of identity and result in pathological identity development. It is reasonable, thus, to suggest that the experience of CPV can affect the process of identity development in a negative way.

While theoretically possible, the role of identity development in the relationship between CPV experiences and DEBs has not been investigated in previous research. Hoof and colleagues (2008) examined the mediating role of personal identity in the relationship between peer victimization experience and depressive symptoms. The results of this study indicated a partial but significant mediation of personal identity, suggesting that the effect of peer victimization on the development of depressive symptoms is predominantly based on adolescents' personal identity. Based on their findings, they proposed that peer victimized adolescents experience more difficulty in integrating their different identities across different contexts, leading to a sense of not being the same person across different contexts. This, in turn, contributes to the development of depressive symptoms (Hoof et al., 2008). Such findings highlight the crucial role of identity development when examining the consequences of CPV.

Emotion Regulation

Emotions arise when a situation is appraised as being important to the individual and are generally defined as biologically based reactions that help individuals respond adaptively to a critical situation (Levenson, 1994). Emotions vary in their frequency, type, duration, and intensity and are often triggered automatically, outside of awareness (e.g., Gross & Munoz, 1995; LeDoux, 1995). Once emotions are triggered, they involve changes in behavioural, physiological and subjective responses that prepare the individual to respond adaptively to the critical situation (Ekman, 1992). Although emotions, due to their imperative quality, can interrupt ongoing activities and change subjective experiences and physiological responses, they do not force us to act in certain ways (Frijda, 1988), they only increase the probability that we will respond in a specific way. This aspect of emotions gives rise to the possibility of regulating emotions (e.g., exaggerate or diminish them).

Emotion regulation is a concept that over the years has been defined in many different ways (e.g., Kring & Werner, 2004). The most influential definition is by Gross (1998b), who defined emotion regulation as "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (Gross, 1998b, pp. 275). According to this definition, that places emphasis on intrinsic factors in regulating emotions, emotion regulation may include alterations in the duration and intensity of the experience of emotion, as well as the behaviour and physiology that result of that emotion. In contrast, Thompson (1994) emphasised the role of extrinsic factors in regulating emotions, specifically the influence of other people in emotion regulation (Thompson, 1994).

According to a functionalist perspective, emotions are important for facilitating adaptive responses to challenging situations (Thompson & Calkins, 1996). For example, fear is an emotion that motivates people to fight, fly or freeze in order to survive in threatening situations. In conceptualizing emotion regulation, researchers supporting the functional nature of emotions emphasised the importance of being aware and understanding the emotions of oneself and suggested that adaptive emotion regulation involves the monitoring, evaluation and modification of the intensity and duration of an emotional experience (Thompson & Calkins, 1996). In 1996, Hayes and colleagues also emphasised the importance of accepting emotional experiences rather than trying to control or avoid them. Specifically, they suggested that attempts to avoid or control emotional experiences may increase emotion dysregulation, which in turn may increase the risk for psychological disorders (Hayes, 1996). In contrast, other authors emphasise the importance of reducing emotional arousal and controlling emotional responses through the process of emotion regulation (Cortez & Bugental, 1994; Garner & Spears, 2000).

Adaptive emotion regulation also requires the consideration of one's long-term goals and values in a given situation and the ability to modulate/express emotional responses that are in line with those goals and values (Linehan, 1993). It requires flexibility in the use of emotion regulation strategies, to be able to inhibit inappropriate behaviours when experiencing negative emotions to allow the individual to behave in accordance with his/her goals and values (Cole, Michel, & Teti, 1994; Linehan, 1993; Thompson, 1994).

The present thesis is based on the conceptualization of emotion regulation offered by Gratz and Roemer (2004), who used the above empirical work and suggested that emotion regulation comprises of four dimensions: a) awareness and understanding of emotions, b) the acceptance of emotions, c) the ability to successfully control impulsive behaviour and engage in goal-directed behaviours when experiencing negative emotions, and d) the ability to use the appropriate emotion regulation strategies. Based on these four dimensions they developed the Difficulties in Emotion Regulation Scale (DERS) that comprises of six factors/processes: a) acceptance of emotions, b) ability to engage in goal-directed behaviours, c) ability to control impulsive behaviours in emotional situations, d) ability to modify emotion regulation based on the situation that one is, e) awareness of emotions, f) ability to understand emotions (Gratz & Roemer, 2004). The DERS assesses emotion regulation strategies that are not adaptive and therefore allows the identification of dysfunctional emotion regulation strategies in individuals. This is why the DERS is considered a useful measure when studying psychopathology (Bloch, Moran, & Kring, 2010).

It is commonly agreed that emotion regulation abilities have a key role in many mental health disorders. Indeed, difficulties in emotion regulation are referred in many diagnostic criteria required for the diagnosis of several psychological disorders in the DSM-5 (American Psychiatric Association, 2013). For instance, the "fear of gaining weight" in the diagnostic criteria for AN indicate difficulties in regulating emotions.

Difficulties in emotion regulation may arise in various ways. For instance, when emotion regulation strategies are not implemented properly (i.e., inflexible, context-insensitive), when the emotions are very intense, or when emotion regulation strategies have not been developed (e.g., Farach & Mennin, 2007). Emotion regulation strategies are considered maladaptive when the resulting emotional response does not change in the anticipated way (i.e., the negative emotion does not decrease) or when the negative long-term consequences that occur because of the changes in emotion are more compared to the benefits of the short-term consequences (Werner & Gross, 2010). Given that emotion dysregulation is implicated in many psychological disorders (e.g., Kring & Bachorowski, 1999), it can be argued that emotion regulation abilities may influence the development of such disorders, including EDs. The following paragraph focuses on describing the role of emotion regulation in eating symptomatology.

Emotion Regulation and Disordered Eating Behaviours

The relationship between emotion regulation difficulties and pathological eating at the subclinical and clinical level is well established (Lavender et al., 2015). The association between eating disorders and emotion dysregulation was initially reported in 1962 by Bruch who observed that individuals diagnosed with AN had significant difficulty in identifying and expressing different emotional states.

The issue has grown in importance in light of more recent findings highlighting the existence of emotion regulation difficulties in individuals who endorse DEBs. For instance, DEBs have been associated with emotion regulation difficulties in non-clinical samples (e.g., Cooper, O'Shea, Atkinson, & Wade, 2014; Wollenberg, Shriver, & Gates, 2015). When examining certain emotion regulation deficits in clinical samples, difficulties in identifying and describing emotions have been shown to be more prevalent in AN (Hatch et al., 2010); BED (Carano et al., 2006) and BN (Harrison, Sullivan, Tchanduria, & Treasure, 2009). In

addition, emotional suppression, avoidance of emotions, rumination and use of self-destructive behaviours are other emotion regulation strategies reported in individuals who exhibit DEBs (e.g., Haynos & Fruzzetti, 2011). Restrictive eating has also been associated with unstable self-concept, mood disorders, and substance abuse (e.g., Abebe, Lien, Togersen, & van Soest, 2012), while the experience of negative emotions in individuals with a diagnosis of eating disorder has been associated with pathological eating behaviours (e.g., Stice, 2002). These findings support the notion that individuals with DEBs have difficulties in emotion regulation.

Several theoretical models for EDs have been proposed highlighting the role of emotions in EDs and how eating disorder behaviours regulate affect (e.g., Cooper, Wells, & Todd, 2004; Fox & Power, 2009; Hawkins & Clement, 1984; Heatherton & Baumeister, 1991). In the theory of restraint eating, Polivy and Herman (1985), highlight the role of negative emotions in triggering binge-eating. They suggested that when individuals restrict their food intake, they are more likely to binge when a disrupting event, external or internal occurs. Such events also include emotions, especially strong negative emotions.

Bruch (1973) argued that overeating could be a response to difficulties in identifying, understanding, expressing and managing effectively internal physical (i.e., hunger) and emotional (i.e., sadness) states. Individuals who have difficulty identifying and regulating their emotions effectively may thus use food in an attempt to manage those negative emotions (Bruch, 1973). The *escape theory*, as mentioned above, suggests that individuals cope with emotional distress by binge-eating as it helps narrow their attention to immediate pleasurable stimuli in their environment (e.g., food) and avoid experiencing internal distress associated with self-awareness (Heatherton & Baumeister, 1991). These theories suggest that binge-eating acts as an emotion regulation strategy, providing means of coping with negative emotional states. Similarly, the Affect Regulation Model for BED (Hawkins & Clement, 1984) suggests that binge-eating is a response to negative affect and functions as a coping

strategy that helps regulate negative affect by providing short-term relief and distraction from negative stimuli (e.g., Heatherton & Baumeister, 1991; Polivy & Herman, 1993). In support of these theories, various studies support the role of negative emotions in triggering binge-eating (e.g., Kittel, Brauhardt, & Hilbert, 2015; Lavender et al., 2015).

Stress and negative emotions are triggers not only for binge-eating but restrictive eating as well. Loss of appetite is considered a normal physiological response to emotional arousal when distressed (Bruch, 1973). When stress is experienced, the fight-or-flight response is activated that includes activation of the sympathetic nervous system. This activation results in increased alertness and suppression of appetite and food intake as blood is diverted away from the digestive system since it is not needed (e.g., Torres & Nowson, 2007).

Literature on restrictive eating as an emotion regulation mechanism is limited. While there is some evidence supporting the function of restrictive eating as an emotion regulation strategy (Haynos, Hill, & Fruzzetti, 2016), it is limited in clinical population with AN diagnosis. Dieting and dietary restraint, constructs that are related to restrictive eating, have been associated with emotion regulation deficits (Stapleton & Whitehead, 2014; Wollenberg, Shriver, & Gates, 2015). However, it has been argued that such constructs reflect the *intention* to restrict eating and not actual dietary restriction (Haynos, Field, Wilfley, & Tanofsky-Kraff, 2015). In support of the emotion regulation function of restrictive eating, a recent study indicated that restrictive eating in non-clinical individuals was associated with specific deficits in emotion regulation, including difficulties engaging in goal-directed behaviour, inhibiting impulsive behaviour, and selecting appropriate emotion regulation strategies when distressed (Haynos, Wang, & Fruzzetti, 2016).

The emotion regulation function of DEBs has been demonstrated in various studies. For instance, Fox (2009), using qualitative data, also revealed that binge and purging behaviours in women diagnosed with AN were mainly described as reducing anger, whereas

restricting behaviours were used to distract individuals from negative feelings, such as sadness, and as a soothing mechanism that temporally helped increase positive feelings and self-esteem. Alpers and Tuschen-Caffier (2001) using a sample of individuals who binged, indicated that there was a strong association between the experience of negative feelings and wanting to eat despite the absence of hunger. Overeating in response to negative emotions was also demonstrated in other studies. For instance, it has been shown that overweight, restrictive, as well as healthy individuals increase their food intake in response to negative emotions (Heatherton, Polivy & Herman, 1990; Newman, O'Connor & Conner, 2007). A metanalysis by Haedt-Matt and Keel (2011) also concluded that individuals with BED or BN experience increase in negative affect preceding their binge-episodes (Haedt-Matt & Keel, 2011). Such studies highlight the occurrence of DEBs as a response to negative emotions and support the idea that DEBs could act as an emotion regulation strategy.

Accordingly, it can be hypothesized that helping individuals learn how to better regulate their emotions could decrease symptoms related to eating pathology. Indeed, a study by Peterson and colleagues (2017) showed that a psychotherapy treatment that focused on increasing emotion regulation abilities for BN was associated with improvements in the frequency of binge-eating, as well as in cognitive symptoms related to eating disorder (Peterson et al, 2017).

Further evidence for the existence of emotion regulation difficulties in individuals with DEBs comes from studies that show high prevalence of alexithymia in individuals with disturbed eating behaviours and with a diagnosis of EDs (e.g., Bydlowskiet al., 2005; Deborde et al., 2008; Zonnevijlle-Bender et al., 2002). Alexithymia refers to a set of characteristics that include a) difficulties in identifying feelings and differentiating between bodily sensations and feelings, b) difficulties in communicating feelings, c) lack of imagination, and d) a concrete cognitive style that is focused on the external environment (Sifneos, 1973). A consistent

finding among individuals with eating pathology when each of these characteristics is examined is that they show specific difficulties in identifying and communicating their feelings. For instance, higher levels of disordered eating behaviours have been associated with higher scores on the factors of The Toronto Alexithymia Scale-20 (TAS-20; Bagby, Parker, & Taylor, 1994) that assess difficulties in identifying and describing emotions (e.g., De Berardis et al., 2007). Moreover, Carano and colleagues (2006) found that the severity of BED was predicted by deficits in identifying and describing emotions.

In summary, there is a robust body of literature suggesting that individuals with DEBs experience difficulties in regulating their emotions. However, little is known about emotion regulation abilities and how they influence the development of DEBs in emerging adulthood within the context of early experiences of peer victimization. The following paragraph examines the literature on the relationship between emotion regulation and CPV.

Emotion Regulation and Childhood Peer Victimization

Difficulties in emotion regulation have been a continuous concern within research on early-onset interpersonal trauma and have been studied as both antecedents and outcomes (e.g., Rosen, Milich, & Harris 2012). The present thesis aims to contribute to this growing area of research by exploring how existing emotion regulation difficulties can influence the relationship between CPV and the development of DEBs in emerging adulthood.

A considerable amount of literature has been published on emotion regulation in individuals who have experienced trauma. Several studies highlight the difficulties in emotion regulation, specifically in tolerating negative emotions in individuals with a history of interpersonal trauma and consequently the desire to avoid these emotions (e.g., Briere & Rickards, 2007). In addition, difficulties in regulating impulses in individuals with early-onset trauma experience (Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997), as well as higher levels of alexithymia have been identified (e.g., McLean, Toner, Jackson, Desrocher,

& Stuckless, 2006), suggesting possible deficits in emotion regulation abilities in those individuals. Further evidence for the prevalence of emotion dysregulation in individuals with interpersonal trauma history comes from Ehrin and Quack (2010) who found that individuals with early-onset chronic interpersonal trauma scored higher on all the processes of emotion regulation assessed by the DERS questionnaire (Ehrin & Quack, 2010).

In examining emotion dysregulation in victims of bullying, Spence and colleagues (2009) found evidence of deficits in regulating the emotions of anger and sadness (Spence et al., 2009). Similarly, Toblin and colleagues (2005) reported deficits in emotion regulation in victims of bullying. Iyer, Kochenderfer-Ladd, Eisenberg, and Thompson (2010) examined effortful control, a construct that refers to the ability of individuals to allocate their attention and manage their emotions and thoughts, and indicated a negative association with peer victimization. This finding suggests that individuals that are victims of bullying have a decreased ability in managing their emotions and thoughts or in shifting their attention away from negative emotions or memories associated with the experience of peer victimization leading to heightened experience of negative emotions.

The evidence presented in this section suggests that emotion regulation difficulties are prevalent in individuals who have experienced early interpersonal trauma, including peer victimization. Such deficits in emotion regulation could create a risk for the development of DEBs in those individuals. Given that emotion regulation is a highly trainable skill, understanding its impact in the relationship between CPV experiences and DEBs is of primary importance as it can be a strong area for intervention.

Experience of Living with Disordered Eating Behaviours

To date, qualitative research that is focused on the experience of binge-eating and restrictive eating has been very limited and to our knowledge none has been conducted on how emerging adults with a history of CPV interpret their experiences with DEBs. For instance, Eli

(2015) examined how women with a diagnosis of BN and AN experience binge-eating. Using a phenomenologically informed thematic analysis they analysed the interviews from sixteen women and results revealed that participants described binge-eating as creating a sense of release or fullness that replaced the existential sense of emptiness. The experiences of release and fulness associated with binge-eating were suggested to contribute to the long-term maintenance of binge-eating.

Espindola and Blay (2009) conducted a metasynthesis of qualitative studies about the meaning that patients with AN ascribe to their disorder. Their analyses indicated that AN is part of the patient's identity. Specifically, the third-order synthesis defined two categories on how individuals with AN understand their symptoms: 1) disease as identity and 2) systems control. *Disease as identity* represents the role of AN in creating a sense of a structured identity for individuals with AN. Increasing food intake and gaining weight for these individuals is thus perceived as a threat to their identity. The second category, *systems control*, represents the mechanisms that perpetuate AN. Espindola and Blay (2009) proposed that individuals with AN express a need for control and success in controlling weight produces a feeling of comfort, which contributes to the maintenance of AN. Similarly, in another qualitative study that analysed 20 life-history interviews with women who have recovered from AN, a common theme that emerged was the 'lack of control' as a significant factor that contributed to the development of their disorder (Patching & Lawler, 2009). The need for control has been central in the etiology and maintenance of EDs, particularly in AN. Bruch (1978), for instance, holds the view that symptoms of AN, including restrictive eating, represent desperate attempts to compensate for the lack of identity and lack of control, sense of ineffectiveness, incompetence experienced in individual's life that is common in AN. Supporting this view, Slade (1982) posited that weight loss in AN gives individuals a sense of control that they lack that helps them cope with negative affect experienced in their life. He

suggested that controlling food intake gives individuals a sense of achievement as it is perceived as a "successful behaviour in the context of perceived failure in all other areas of functioning" (Slade, 1982, pp. 173). Similarly, other authors emphasise individual's fear of loss of control as contributing to the maintenance of AN (Crisp, 1995).

The research described above indicates that BN and AN are functional in a way and are in line with results from quantitative studies mentioned above (e.g., Heatherton and Baumeister, 1991). Similarly, Nordbo, Espeset, Gulliksen, Skarderud and Holte (2006) interviewed eighteen women with AN to examine the meaning that individuals with AN attribute to their symptoms and identified eight themes that support the functional role of AN. In particular, Nordbo and colleagues (2006) reported that AN gave participants a sense of security, mastery and self-confidence, helped them avoid negative feelings, achieve a sense of identity and communicate their difficulties with other people, elicited care from others and for some of the participants AN contributed to their wish to die.

Another useful study is by Nilsson, Abrahamsson, Torbiornsson and Hagglof (2007) that focused on examining recovered patients' understanding of how their AN emerged. Results indicated that adolescents considered different socio-cultural causes for their AN, including problems with peers/bullying, difficult situations at school and normative social pressure. Koruth, Nevison and Schwannauer (2012) utilized a grounded theory approach and found that adolescents associated AN with identity issues. Similarly, in a recent metasynthesis on qualitative studies, Sibeoni and colleagues (2017) reported that adolescents underlined identity-related characteristics as a cause for their AN across many studies.

Despite previous literature on the personal experience of eating symptomatology, most of these studies focus on individuals with a clinical diagnosis of either BN or AN, ignoring other subclinical forms of EDs (i.e., DEBs) that do not meet the diagnostic criteria of the EDs listed in DSM-5 (DSM-5; American Psychiatric Association, 2013). This is concerning given

the high prevalence of DEBs in the population (Ricciardelli & Yager, 2015). Additionally, no study has been conducted on how emerging adults with a history of CPV interpret their experiences with DEBs to date. The qualitative phase of the present thesis, therefore, focuses in examining how emerging adults who also have a history of CPV interpret their experiences with DEBs and how they make sense of the CPV experience in relation to their current DEBs.

Chapter Three: Rationale and Objectives

In light of the literature reviewed above, the major objective of the present thesis was to enhance the literature on the development of DEBs in emerging adulthood by investigating an area that has not been examined before. This was achieved in two phases. Phase one, the quantitative phase, was primarily concerned with the investigation of the relationship between the harmfulness of the CPV experiences and DEBs in emerging adults and how identity development and emotion regulation abilities contribute to this relationship, while taking into consideration the effects of gender and BMI. Expanding the literature in this area can encourage the development of targeted interventions that aim at reducing the risk for the development of EDs.

Phase two aimed to complement the quantitative self-report data by obtaining qualitative data through in-depth semi-structured interviews on emerging adults' lived experiences of DEBs and how they make sense of the CPV experience in relation to their current DEBs. To date, literature on the lived experiences of emerging adults with a history of CPV in regard to restrictive and binge-eating behaviours is limited. The present thesis utilized interpretative phenomenological analysis (IPA) as it focuses on how participants interpret and make sense of important life experiences and thus enables researchers to gain detailed understanding of how certain phenomena are experienced (Smith et al., 2013).

Research Aims

The present thesis was guided by four primary goals. First, to examine whether the harmfulness of the CPV experiences predict the development of DEBs in emerging adulthood. Second, to investigate the indirect relationship between CPV harmfulness and DEBs through identity development. Third, to investigate whether difficulties in emotion regulation abilities moderate the relationship between the harmfulness of the CPV experience and the development of DEBs in emerging adulthood. Fourth, to gain a deeper understanding on how

emerging adults who also have a history of CPV interpret their experiences with DEBs and how they make sense of the CPV experiences in relation to their current DEBs.

Research Questions

Quantitative Phase

1. What is the effect of CPV harmfulness on the development of DEBs in emerging adulthood?
2. Is there an indirect relationship between CPV harmfulness and DEBs through pathological identity development in emerging adulthood?
3. Does CPV harmfulness have different effects on the development of DEBs in individuals who report high levels of emotion regulation difficulties compared to those who report low levels of emotion regulation difficulties?

Qualitative Phase

1. How do emerging adults with a history of CPV interpret their experiences with DEBs and how do they make sense of the CPV experience in relation to their current DEBs?

Hypotheses

In accordance with the literature outlined in chapter two, the following research hypotheses were examined:

1. Harmfulness of the CPV experience would be positively associated with DEBs
2. Harmfulness of the CPV experience would be positively associated with DEBs through pathological identity development
3. The relationship between the harmfulness of the CPV experience and the development of DEBs would be stronger in emerging adults who report high levels

of emotion dysregulation compared to those who report low levels of emotion dysregulation

Chapter Four: Methodology

Design

The current thesis used an explanatory sequential mixed methods design. This design was chosen as it offers the ability to integrate two different types of information using quantitative and qualitative research methods and thus reach a more comprehensive understanding of the research problem (Creswell, 2014). For the current thesis, quantitative data was first gathered in phase one using an online survey and then in the second phase, semi-structured interviews were used to gather qualitative data.

Ethics

Ethical approval for this thesis was obtained from the Cyprus National Bioethics Committee (Folder no.: ΕΕΒΚ/ΕΠ/2019/10). Strict ethical standards were held as described by the APA Ethical Principles of Psychologists and Code of Conduct (2017).

Quantitative Phase

Participants

Participants were recruited from the community using advertisements posted in public places (e.g., using flyers), online advertisements and notices. There were three exclusion criteria: a) current bullying experience, b) experienced bullying after 18 years of age, c) older than 25 years old or younger than 18.

In total, around 5,000 people were contacted to take part in the study. Out of these individuals, 706 entered the webpage to complete the online survey. All 706 participants opened the survey, but their responses could not be analysed since less than 50% of the survey was completed. Disruptions of the internet and other errors related to the computer and internet, as well as the time needed to complete the survey are possible reasons that could have affected the completion rate. In total, 457 participants completed the whole survey. From the

457 participants, 26 (5.69%) were older than 25; two (0.44%) were younger than 18; and 14 (3.06%) reported experiencing bullying after 18 years old. Therefore, 42 (9.19%) participants in total were excluded from the study. Additionally, in the process of data screening for multivariate outliers, one case was deleted based on its' squared Mahalanobis distance value (Byrne, 2010).

The final sample consisted of 414 individuals, 94 males (22.7%) and 320 females (77.3%). All participants were Caucasian and had Greek as their first language. The age of participants ranged from 18 to 25 years (M = 21.36, SD = 2.15). With regards to the body mass index (BMI) of participants, values ranged from 13.97 to 48.93 (M = 22.72; SD = 4.15). In terms of nationality, 348 (84.1%) were Greek Cypriots, 58 (14.0%) were Greeks and the other eight participants (1.9%) had other nationalities including British Cypriot, French, Romanian and Belarusian nationalities. In regard to education 138 (33.3%) of the participants reported having a university degree or higher, 275 (66.4%) of the participants reported having a high school degree and were currently undergraduate students and one participant (0.2%) reported having less than a high school degree. More than half of the sample was not employed at the time of the study (71%).

Measures

Experience of Childhood Peer Victimization. *The Retrospective Bullying Questionnaire* (RBQ; Schäefer et al., 2004) was used to measure CPV during primary and secondary school. The Greek version of the RBQ (Kritsotakis, Papanikolaou, Androulakis, & Philalithis, 2017) was used in the present study. The RBQ is a self-report scale that retrospectively measures peer victimization experiences. The scale consists of 44 items that assess different forms peer victimization at two different time points (i.e., primary and secondary school) and focuses on the frequency and intensity of the experience. Frequency is assessed by asking participants to rate how often each incident occurred (i.e., from 0 = "This

never occurred" to 4 = "This was happening constantly") and perceived intensity is assessed by asking participants how serious each experience was for them (i.e., 0 = "I wasn't bullied" to 4 = "Extremely serious").

The current study used only the items assessing the frequency and intensity of CPV in both primary and secondary school to create a composite *harm* score for each incident (Harm = Frequency x Perceived intensity of bullying incident) as suggested in the review by Volk, Dane and Marini (2014).

The RBQ has demonstrated good test-retest reliability (i.e., $r = 0.88$, $p < .01$ for elementary school victimization, $r = 0.87$, $p < .01$ for middle or high-school victimization, and $r = 0.77$, $p < .01$ for trauma over a two-month period) (Schäefer et al., 2004; Jantzer, Hoover, Narloch, 2006). The Cronbach's alpha coefficient computed for this scale in the present sample was .84 for frequency and .83 for perceived intensity, indicating good internal consistency.

Disordered Eating Behaviours. Restrictive eating behaviours were measured through the five-item *restraint subscale* from *The Eating Disorder Examination Questionnaire* (EDE-Q; Fairburn & Beglin, 1994; Giovazolias, Tsaousis, & Vallianatou, 2013). The EDE-Q has demonstrated excellent internal consistency in earlier studies (Peterson et al., 2007; Giovazolias, Tsaousis, & Vallianatou, 2013). In the current sample, the Cronbach's alpha computed for this scale was .81, indicating very good internal consistency.

The seven-item *bulimia subscale* of *The Eating Disorder Inventory–3* (EDI–3; Garner, 2004; Hadjigeorgiou, Tornaritis, Savva, Solea, & Kafatos, 2012) was used in the current study to assess the presence of binge-eating behaviours. This instrument has been employed in a number of studies using Cypriot sample and showed good psychometric properties (e.g., Hadjigeorgiou, Tornaritis, Savva, Solea, & Kafatos, 2012). In the present sample, the Cronbach's alpha coefficient for this scale was .80, indicating very good internal consistency.

Identity Development. The *Assessment of Identity Development and Identity Diffusion in Adolescence* was used to measure identity development (AIDA; Goth et al., 2012; Jung et al., 2012; Tantaros, Besevegis, & Pavlopoulos, 2017). It is a self-report questionnaire for adolescents and young adults that consists of items assessing pathology-related identity development based on the dimensions of discontinuity and incoherence. Higher scores indicate higher level of identity diffusion and thus impairment. AIDA has been shown to have good psychometric properties (Goth et al., 2012). In the present sample, the Cronbach's alpha for the AIDA total score was .93, indicating excellent internal consistency.

Emotion Regulation Difficulties. The Greek version of the *The Difficulties with Emotional Regulation Scale* (DERS; Mitsopoulou et al., 2013) that is based on Gratz and Roemer (2004) was used. The DERS is a self-report questionnaire that consists of 36 items and assesses individuals' capacity to regulate their emotions. It consists of six subscales: 1) Non-acceptance of emotional responses, 2) Difficulties engaging in goal directed behaviour, 3) Impulse control difficulties, 4) Lack of emotional awareness, 5) Limited access to emotional regulation strategies, and 6) Lack of emotional clarity. Scores are based on responses on a 5-point Likert type scale, ranging from 1 (almost never) to 5 (almost always). In addition to a distinct score for each subscale, a total score is calculated that represents an individual's competence in regulating his/her emotions. The scores can range from 36-180. Higher scores represent poorer emotional regulation abilities. While there are no standardized clinical cut-off scores, research suggests that the clinical range on the DERS total score ranges from 80 to 127 (Harrison, Sullivan, Tchanturia, & Treasure, 2010; Staples & Mohlman, 2012).

Previous studies demonstrated excellent psychometric properties for the DERS questionnaire in both clinical and non-clinical samples (Gratz & Roemer, 2004; Lavender et al., 2014). The Cronbach's alpha for the DERS total score in the present sample was .91, indicating excellent internal consistency.

Procedure

A cross-sectional retrospective design was used in the quantitative phase. This involved asking participants to recall past experiences of peer victimization and then assess how they relate to DEBs at present.

Data was collected through an online survey (Appendix B), consisting of five different sections, each containing a different questionnaire. The survey for participants was administered via a secured website (i.e., Survey Monkey) and was accessible via a URL that was sent to the last known working e-mail address of the individuals who agreed to take part. The URL was also made accessible via Facebook.

An informed consent was obtained online from all participants before the start of the study (Appendix A). Once participants opened the specific site on the web, a page opened up asking participants their age and consent for participating in the study. To ensure confidentiality, the survey did not ask for the participants' names or other information that could identify the participants. However, if they wished to take part in the qualitative phase, they were required to give their email or telephone number at the end of the survey. Participants were assured that the information they have given would only be used for the purpose of the study only. Contact details of the research team were also included at the beginning and at the end of the survey in case the participants had further questions. Contact details for further help or psychological support to the participants (i.e., psychological services) was also provided at the end of the survey.

Only personal data that were strictly necessary for the research being undertaken was collected. All information collected was only accessible by the researcher of the study and was stored in a password protected USB in the researcher's office that was locked when left unattended. Data was not used for any other purpose without receiving further consent from the participants.

Analysis Plan

Before conducting the analyses, IBM Statistical Package for the Social Sciences (SPSS) version 24 was used to screen all the variables for missing values, outliers, normality and linearity.

Structural Equation Modelling (SEM) was chosen as the primary analytic technique for the present study since it is considered an ideal analytic approach for the examination of the factor structure of measurements and the structural relationship between variables (Byrne, 2009). The maximum likelihood (ML) estimation method was used, and all analyses was conducted using Analysis of Moment Structures (AMOS) software, version 20 (Arbuckle, 2011).

The validity of the models was evaluated through the assessment of several model fit indices, including the chi-squared goodness of fit statistic (χ^2), the Comparative Fit Index (CFI), the Tucker Lewis index (TLI) and the Root Mean Squared Error of Approximation (RMSEA) and the Standardized Root Mean Square Residual (SRMR) (e.g., Byrne, 2009). Adequate fit is indicated by non-significance of the chi-square value (Meydan & Sen, 2011). For the CFI and TLI values above 0.90 and close to 1 indicate good fit with values over .95 indicating excellent fit (Schermelleh-Engel, Moosbrugger, & Müller, 2003). For the RMSEA, values less that 0.05 indicate good fit (Bayram, 2013) and values between 0.05 and 0.08 show acceptable fit (Byrne, 2010). Finally, for the SRMR, values less than .05 indicate excellent fit (Byrne, 1998) and values above .05 to .08 indicate adequate fit (Hu & Bentler, 1999).

First, the psychometric properties of EDI-3 and EDE-Q were examined. Confirmatory Factor Analysis (CFA) was performed to examine their structural validity. Model revisions were made based on modification indices (MIs). Following that, Structural Equation Modelling (SEM) was implemented to investigate the relationship between the variables under examination.

The effect of CPV harmfulness on DEBs was examined in Model 1, while the indirect relationship of CPV harmfulness on DEBs through pathological identity development was examined in Model 2.

To assess the moderating role of emotion dysregulation, a multigroup analysis was conducted. The sample was divided in two groups based on their total score on the DERS questionnaire (i.e., high emotion dysregulation/clinical range, n = 257; low emotion dysregulation, n = 157). Those who had an average of 80 and higher formed the high emotion dysregulation (clinical range) group, while those that scored below 80 formed the low emotion dysregulation group (Harrison, Sullivan, Tchanturia, & Treasure, 2010; Staples & Mohlman, 2012). Separate models were tested based on the two groups. The chi-square difference test was used to examine whether constraints significantly worsened model fit (Wang & Wang, 2012).

Qualitative Phase

The aim of the qualitative phase was to validate and expand on the results obtained from the quantitative phase by gaining an in-depth understanding of emerging adults' lived experiences of DEBs and how they make sense of their CPV experience in relation to their current DEBs.

Analytic Approach

Interpretative Phenomenological Analysis (IPA) approach was used for the analysis of the qualitative data. Interpretative Phenomenological Analysis is a qualitative approach that focuses on how participants interpret and make sense of their lived experiences (Smith et al., 2013) and thus enables researchers to gain detailed understanding of how certain phenomena are experienced. A distinct feature of IPA is that while it focuses on what is unique (i.e., unique experience of each individual), at the same time it focuses on what is shared across individuals' stories and therefore produces a comprehensive account of patterns of meaning

reflecting the shared experiences of participants (Smith, Flowers, & Larkin, 2009). Given IPA's prime interest on how individuals make sense of their lived experiences, IPA was deemed a suitable approach for the analysis of the data in the current phase of this thesis.

Participants

Since IPA is concerned with examining the lived unique experiences with DEBs of emerging adults with a history of CPV, participants were selected based on the particular research question and on the insights that individuals could offer for the experience under examination (Smith, Flowers, & Larkin, 2009). Purposeful sampling was therefore used for phase two. Among the 414 participants that took part in phase one, 217 (52.4%) consented to take part in the second phase and provided contact details as part of completing the online questionnaire in phase one.

As mentioned above, the central aim of the qualitative phase was to gain a deeper understanding of how emerging adults with a history of CPV interpret their experiences with DEBs. In addition, the findings of the present thesis were used to validate and gain an in-depth understanding of the quantitative results from phase one. Therefore, individuals who reported a history of CPV and scored a specific threshold on either measure of the DEBs were considered suitable for phase two. The mean score and standard deviation of the mean for each DEBs measure was first calculated to determine the upper boundary that determined the participants that were considered eligible for phase two. With regards to the binge-eating behaviours, the mean score and standard error of the mean for EDI-3 were 15.12 and 5.37 respectively. Thus, participants who scored 20.49 and higher were considered eligible for phase two. With regards to the restrictive eating, the mean score and standard error of the mean for EDE-Q were 2.48 and 1.42. Participants who scored 3.90 and higher were considered eligible for phase two.

Those meeting the inclusion criteria mentioned above were contacted via email by the researcher and arranged a time and date for the interview to take place (Appendix C). In total, six participants were interviewed, at which point data saturation was achieved.

Interpretative Phenomenological Analysis is concerned with the thorough examination of individuals' lived experiences and studies using IPA are therefore conducted on a relatively small sample size (Smith, Flowers, & Larkin, 2009). Smith and colleagues (2009) suggest that in IPA studies, emphasis should be placed on quality, not quantity, and argue that important details of individuals' experiences may be lost with lager samples. For this reason, they suggest between four to ten interviews for professional doctorate research projects (Smith, Flowers, & Larkin, 2009). Table 1 provides a summary of the personal characteristics of the participants that took part in this phase of the present thesis.

Table 1

Participants' Personal Characteristics

Participant Code	Gender	Age	BMI	Current employment status	Nationality	DEB exhibited
PA	Male	21	29.98	Student and employee	Greek Cypriot	Binge-eating
EZ	Female	21	44.46	Student and employee	Greek Cypriot	Restrictive and Binge-eating
TP	Female	25	19.31	Student and employee	Greek	Restrictive
PG	Female	18	19.68	Student	Greek Cypriot	Restrictive and Binge-eating
RI	Female	24	26.84	Student	Greek Cypriot	Binge-eating
DK	Female	22	24.03	Student	Greek Cypriot	Restrictive and Binge-eating

Interview Protocol

The questions for the semi-structured interviews were based on the aims of the current phase, which were to gain an in-depth understanding of how emerging adults with a history of CPV: 1) interpret their experiences with DEBs, and 2) make sense of the CPV experience in relation to their current DEBs.

Since a key aim of this phase was to explore and gain a deeper understanding of participants' live experiences, open-ended questions were deemed suitable. The interview

protocol, therefore, included five major open-ended questions with possible prompts (Appendix E). As it can be seen in Appendix E, at the beginning, participants were asked to describe themselves in as much detail as they could so as to gain an insight into participants' identity and how they view themselves. The following questions were about their experiences with DEBs. The first question was about their general understanding of DEBs. This question was followed by different prompt questions depending on participant's responses. The following questions were about their own experience of DEBs and were encouraged to provide an account of their DEBs history. Questions were asked about the type of DEBs they exhibit currently, age of onset, frequency and duration. After these questions, participants were asked about the role they believe that DEBs play in their life and whether they believe their DEBs are triggered by specific events (internal or external). Different prompt questions depending on participant's responses were asked. The following set of questions examined the participants' experience of peer victimization during their childhood and their understanding of whether there is a connection between their CPV experiences and their current DEBs. After that, there was a set of questions and prompts on how participants respond to different emotions and their experience of these. Finally, a set of questions on their family environment and eating behaviours while growing up was also included.

Two pilot interviews with non-participating individuals known to the researcher took place. These highlighted that some questions included terms that were very abstract and were therefore revised.

Procedure

Interviews lasted between 26 to 63 minutes depending on each case and were conducted in the form of conversations. All interviews were conducted online using Zoom Video Communications Inc. (Zoom) since conducting interviews face-to-face was not feasible due to the coronavirus pandemic (COVID-19). All interviews were audio recorded.

Participants were informed that the conversation will be recorded and that their participation would remain anonymous. They were also informed that they could end the interview at any point that they wished.

Once participants were settled, the researcher described their position (i.e., a PhD student in Clinical Psychology), explained the aim of the interview and the confidentiality policy and were then asked if they had any questions. This was done to establish rapport with the participants that is considered important for obtaining valuable data (Kvale & Brinkmann, 2009). The day before the interview, the informed consent was sent to each participant's email asking them to sign it electronically and send it back to the researcher.

Conducting interviews online has several benefits and evidence suggests that there are no significant differences in the type of participants' responses or in the quality of the interviews when compared to face-to-face interviewing (e.g., Deakin & Wakefield, 2013). For instance, the most significant advantage is the accessibility to participants. When using online video conferencing, researcher and participant don't need to be in the same geographical location removing factors such as geographical location and funding for travel and thus making cross-national research easier (e.g., Deakin & Wakefield, 2013; Gray, Wong-Wylie, Rempel, & Cook, 2020). Moreover, researchers that compared face-to-face interviewing versus video conferencing found that participants using video conferencing were more expressive than those in face-to-face interviews (Deakin & Wakefield, 2013). The interview process can also be less stressful for participants and more convenient as it can be done in a more familiar environment, such as their home or work (Wood & Griffith, 2007c). In addition, since the interviews took place during the 2020 coronavirus pandemic (COVID-19), conducting interviews online was safer.

Transcription

In line with the IPA recommendations, the researcher transcribed verbatim all interviews (Smith, Flowers, & Larkin, 2009). All transcriptions took place at the researcher's office using headphones to ensure confidentiality and privacy at all times. The audio-recordings were stored in a USB that was kept in a secure place, password protected, at the researcher's office and only the researcher had access. The audio recordings will be destroyed one year after the project is completed. To retain anonymity, any identifiable information was removed from the transcripts and was stored separately (Smith, Flowers, & Larkin, 2009).

In each transcript a space was allowed between each turn. Each transcript also had wide margins on both sides of the paper, as suggested by Smith and colleagues (2009), for the IPA analytic process to be carried out.

Data Analysis

In keeping with the idiographic approach of IPA, each interview was analysed in-depth before moving to the next one (Smith, Flowers, & Larkin, 2009). The analysis procedure was guided by six steps as detailed by Smith and colleagues (2009): 1) Reding and re-reading, 2) Initial noting, 3) Developing emergent themes, 4) Searching for connections across emergent themes, 5) Moving to the next case, 6) Looking for patterns across cases.

The first step, *reding and re-reading*, included reading the transcript several times to ensure familiarity with the content and highlighting text that seemed important. Step two, *initial noting*, examined the semantic content and the language used by the participants during the interview. Initial observations and annotations were made in the right margin of each transcript and included descriptive, linguistic and conceptual comments. At this step, the transcript was uploaded into Atlas.ti (Atlas.ti 8 Windows), a Computer Assisted Qualitative Data Analysis Software (CAQDAS) and used for the initial coding of the data. Step three, *developing emergent themes,* involved exporting the initial codes and related data extracts

from Atlas.ti into Microsoft Excel that were then printed out. For the development of subordinate and superordinate themes, codes were first manually sorted into subordinate themes by the researcher. All the subordinate themes that were created were typed and then printed out to help with the development of superordinate themes. The next step, *searching for connections across emergent themes*, involved looking for patterns and connections across the subordinate themes. Different strategies were used for the creation of superordinate themes. For instance, themes that were related and represented similar understandings were placed together and a new name was created for that cluster of themes.

In line with idiographic approach of IPA, this approach was followed for each transcript; each transcript was coded independently, and a thematic list was created for each participant and saved as a different document (step five; *moving to the next case*). Transcripts were read again and the codes from all the transcripts were crosschecked. Once this process was completed, a common list of all the codes for all transcripts was created. The analysis proceeded by developing groups of related codes and focusing on connections and common themes across cases to identify the final superordinate themes that best describe the experiences of the participants (step six; *looking for patterns across cases*) (Smith, Flowers, & Larkin, 2009).

Approach to Validity and Quality

Different guidelines have been produced for assessing validity and quality in qualitative research. The present thesis follows Yardley's (2000, 2008) principles for assessing quality in an IPA study as recommended by Smith and colleagues (2009). The four principles for good quality research according to Yardley (2000, 2008) include: a) sensitivity to context, b) commitment and rigour, c) transparency and coherence, and d) impact and importance.

The first principle, *sensitivity to context*, can be established by indicating sensitivity to the related literature and the information obtained from the participants of the study (Yardley,

2000, 2008). Sensitivity to literature was addressed through awareness of the relevant literature in the field of disordered eating and eating symptomatology in general. These aspects were demonstrated through the theory included in the literature review section of the present thesis. Sensitivity to the material obtained from the participants was demonstrated by systematically describing and supporting the arguments made with verbatim extracts from the participants. According to Smith and colleagues (2009), this approach allows participant's voice to be heard and at the same time does not extinguish the interpretations being made.

The second principle of *commitment* and *rigour* was established by the researcher by being attentive to participants during data collection, competent in the method used (this involved rigorous study of the guidelines of conducting an IPA study) and by ensuring clear engagement with the subject under study. In addition, according to Smith and colleagues (2009), in IPA the rigour of the analysis is indicated by how thoroughly, systematically and how sufficient idiographic engagement it shows. To demonstrate these, the analysis in the present thesis has drawn upon different strategies including: 1) line-by-line analysis of the claims and understanding of each participant, 2) identification of emergent themes across participants, and 3) identification of the relationship between the themes. In addition, efforts were made to be sufficiently interpretative of the data and to provide extracts from each participant to support each theme.

The third principal is *transparency* and *coherence.* Transparency was enhanced by including details about the process by which participants were recruited, how the interview was developed and conducted, and about the procedure of analysis. In addition, the interview protocol was attached as an appendix (Appendix E), which further improves the transparency of the current research. Coherence was addressed by ensuring a comprehensible link between the research question, the philosophical perspective and the theoretical assumptions of the approach that has been chosen for analysis.

Yardley's (2000, 2008) final principal is *impact* and *importance*. She argues that the most decisive way to judge whether a research is valid is whether it offers something important, interesting and useful to the reader. Accordingly, implications of the current research are discussed in the *Discussion* section of the present thesis.

Reflexivity

Reflexivity refers to the examination of one's own influence on the research process (Yardley, 2000). Interpretative Phenomenological Analysis involves the researcher attempting to make sense of the participants' own understanding of their experiences. This is described as a 'double hermeneutic' (Smith, 2004). As IPA acknowledges the central role of the researcher in the analysis and interpretation of participants' experiences, it is important that researchers using the IPA framework are aware of how their own beliefs and assumptions about how the research could influence the collection and analysis of the data to ensure that assumptions are limited. Being reflective in their interpretations of the data helps achieve this.

Throughout the process of conducting the interviews and analysing them in the current research, the researcher was aware of how her personal and professional experiences may have influenced both processes. The researcher is a trainee clinical psychologist who have had four years of experience in working clinically with individuals who experience psychological difficulties including anxiety disorders, obsessive-compulsive disorder, depression, personality disorders, as well as eating disorders. Throughout the research, the researcher kept reflexive notes in which she documented her thoughts on the research and the data being collected. This helped to identify and reflect on personal assumptions, views and emotional responses in relation to the data being collected from the interviews. According to Smith and colleagues (2013), this process helps researchers to 'bracket off' preconceived assumptions that they may bring during the process of analysing the data. In addition to this, findings of the current

research were discussed with a research supervisor to ensure that the interpretations made were prompted by the data.

Chapter Five: Results

Quantitative Phase

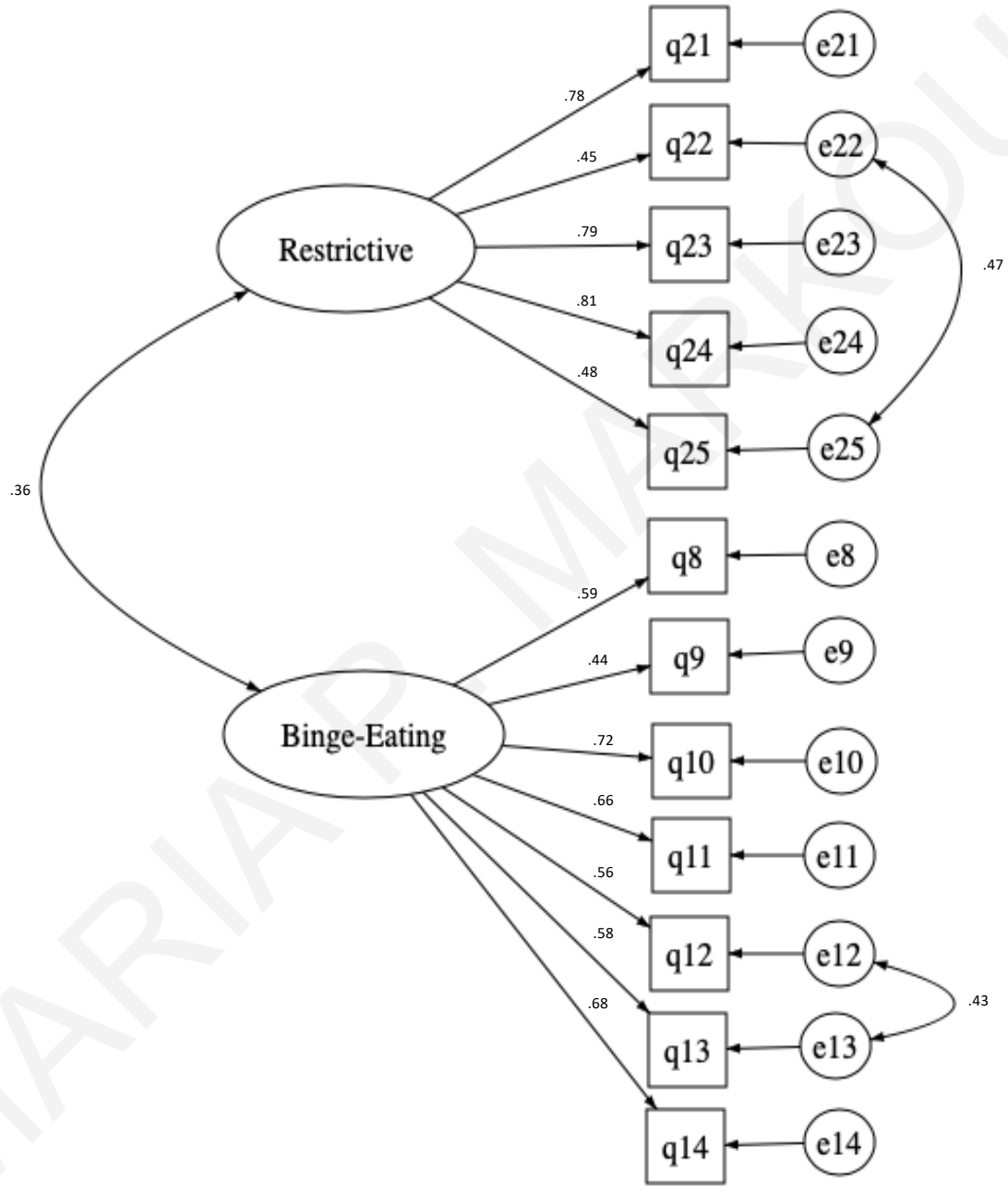
Psychometric Properties

A CFA was initially conducted to assess the psychometric properties of the two subscales used from the EDE-Q and EDI-3 questionnaires. This model was specified to capture two latent constructs (i.e., restrictive eating behaviours and binge-eating behaviours) with their associated observed variables.

All of the parameters and fit indices of the present measurement model were estimated using the maximum likelihood (ML) method. An inspection of the model fit indices suggested that the fit of the data to the initial hypothesized model was not adequate [χ^2 (53) = 305,74, $p < .001$, CFI = .85, TLI= .81, RMSEA= .11, SRMR= .07]. Accordingly, model adjustments were made based on the modification indices related to the covariances. There was a clear evidence for misspecification associated with two pairs of error terms associated with items 22 and 25 (i.e., er22 - er25; MI = 86.28) and items 12 and 13 (i.e., er12 - er13; MI = 58.53). These measurement error covariances were not surprising given the high degree of overlap between each of these items' pairs' content. Following these modifications of the model, the measurement model was re-estimated. Inspection of the model fit indices indicated an adequately fitting model [χ^2 (51) = 143.18, $p < .001$, CFI = .95, TLI= .93, RMSEA= .07, SRMR= .05]. Accordingly, it was decided to proceed with this revised model for the subsequent analysis (Figure 1). This decision was also made based on the fact that the model parameters were in the expected direction.

Figure 1

First-Order Confirmatory Factor Analysis for Restrictive and Binge-Eating



Note. All modelled correlations and path coefficients are significant ($p < .05$)

The descriptive statistics for the variables of the study, along with the Pearson correlation coefficients are presented in Table 2. There was no missing data.

Table 2

Mean, Standard Deviations and Pearson Correlations between Study Variables

Variable	1	2	3	4	5	6
1. CPV harmfulness	–					
2. Restrictive eating	.13**	–				
3. Binge eating	.16**	.29**	–			
4. Identity Diffusion	.30**	.15**	.40**	–		
5. BMI	.06	.26**	.19**	.17**	–	
6. Difficulties in Emotion Regulations	.26**	14**	.42**	.65**	.06	–
M	43.37	2.48	15.12	90.54	22.72	85.89
SD	64.73	1.42	5.37	24.56	4.15	18.71

Note. *p < .05, **p < .001, M = Mean, SD = Standard deviation

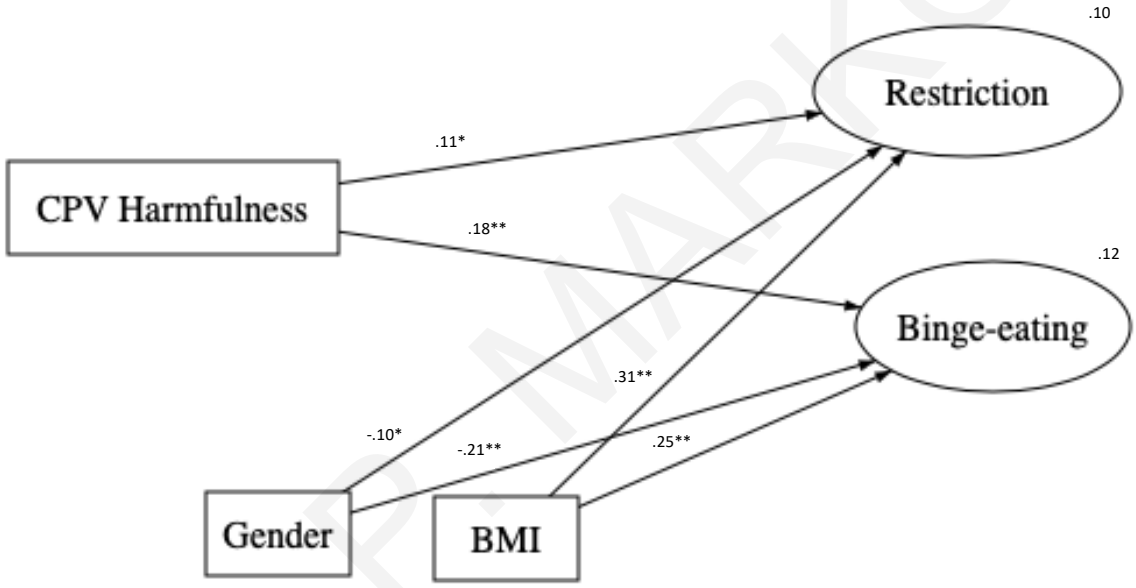
Effects of CPV Harmfulness on DEBs

First, the structural model (Model 1; figure 2) was examined. In this model, CPV harmfulness was set to load on the two DEBs latent variables and at the same time gender and BMI were entered as covariates, with direct paths from these variables leading to both DEBs. Model fit indices indicated a good fit to the data [χ^2 (81) = 188.50, p < .001, CFI = .94, TLI= .92, RMSEA= .06, SRMR= .05] and parameters were in the expected direction. Model 1 along with standardized estimates is presented in figure 2. Harmfulness of the CPV experience was found to be significantly associated with both binge-eating (β = .18, p < .001, SE = .001) and restrictive eating (β = .11, p = .035, SE = .001). Gender, that was set as a covariate in the relationship examined, had a negative significant effect on binge-eating (β = -.21, p < .001. SE = .104) and on restrictive eating (β = -.10, p = .051, SE = .226) indicating that females reported more binge-eating and more restrictive eating than males. BMI was also found to

significantly predict both binge-eating (β = .25, p < .001, SE = .011) and restrictive eating (β = .31, p < .001, SE = .023). All significant effects were in the expected direction. The overall model explained 12% of the variance in binge-eating and 10% of the variance in restrictive eating.

Figure 2

Structural Equation Model (Model 1) Predicting DEBs from CPV Harmfulness



Note. All coefficients shown are standardized. Only significant effects are presented. Values placed over the endogenous variables represent squared multiple correlations.

*p ≤ .05, **p < .001

The Indirect Relationship of CPV Harmfulness on DEBs through Pathological Identity Development

Analysis proceeded with the examination of the indirect effect of CPV harmfulness on DEBs through pathological identity development. Model 2 was the same as Model 1 with the addition of pathological identity development. Structural paths were added from CPV harmfulness, gender and BMI towards pathological identity development and from

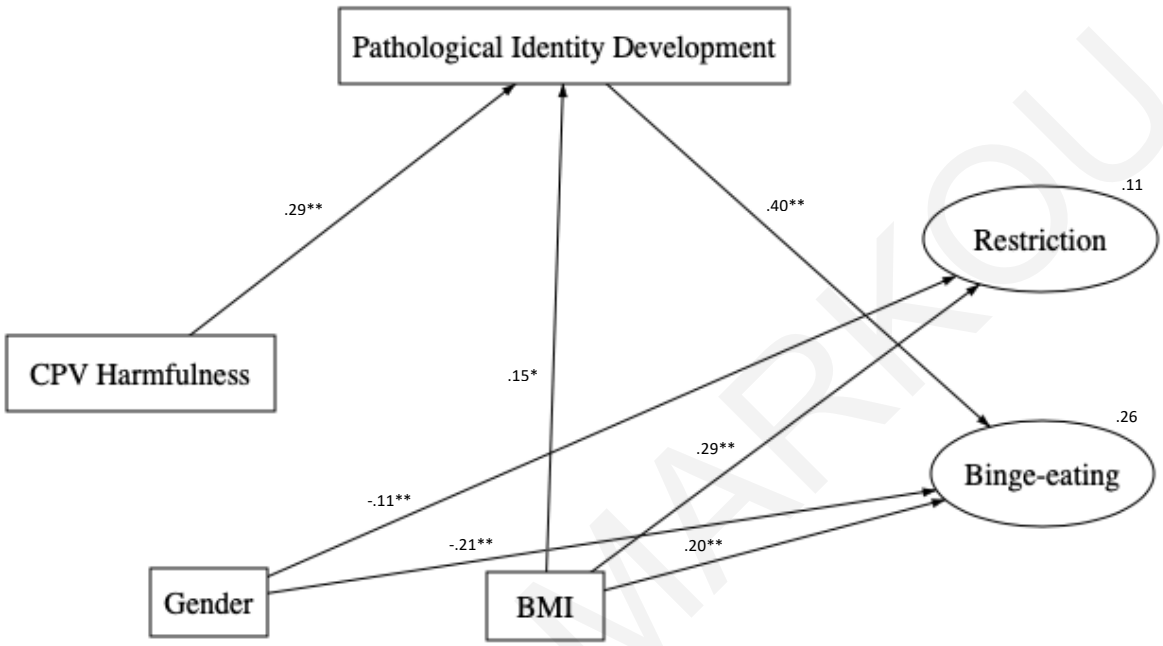
pathological identity development towards restrictive and binge-eating. The model presented an adequate fit to the data [χ^2 (91) = 200.27, p < .001, CFI = .94, TLI= .92, RMSEA= .05, SRMR= .05] and parameters were in the expected direction. Model 2 along with standardized estimates is presented in figure 3. As may be seen, CPV harmfulness seems to affect binge-eating through pathological identity development. In this model, all significant direct effects from CPV harmfulness to DEBs that were significant in Model 1 were found to be statistically non-significant.

Childhood peer victimization harmfulness significantly predicted pathological identity development (β = .29, p < .001, SE = .018) and pathological identity development significantly predicted binge-eating (β = .40, p < .001, SE = .002). However, no significant effect of pathological identity development on restrictive eating was found (β = .07, p = .191, SE = .004).

In regard to the BMI, a significant association with pathological identity development was found (β = .15, p = .002, SE = .286) indicating that it had an indirect effect on binge-eating. Body Mass Index (BMI) was also directly associated with binge-eating (β = .20, p < .001, SE = .010) and restrictive eating (β = .29, p < .001, SE = .023). The negative significant effect of gender on binge-eating remained the same as in Model 1 (β = -.21, p < .001, SE = .098). Gender was also significantly associated with restrictive eating in a negative way (β = -.11, p = .05, SE = .226).

Figure 3

Structural Equation Model (Model 2) Predicting DEBs from CPV Harmfulness Through Identity Diffusion



Note. All coefficients shown are standardized. Only significant effects are presented. Values placed over the endogenous variables represent squared multiple correlations.

*p ≤ .05, **p < .001

The bootstrap estimates of the total, direct and indirect effects of CPV harmfulness on DEBs, through pathological identity development are presented in Table 3. These results support the indirect effect of CPV harmfulness on binge-eating through pathological identity development described above. The overall model explained 26% of the variance in binge-eating and 11% of the variance in restrictive eating.

Table 3

Bootstrap Estimates of the Direct, Indirect and Total Effects of CPV Harmfulness on DEBs with Standard Errors, 95% Confidence Bounds and Statistical Significance

Direct effects			Estimate	Standard error	Lower bound[a]	Upper bound[a]	*p*
CPV Harmfulness	→	Pathological identity	.29	.04	.21	.37	.00
CPV Harmfulness	→	Restriction	.09	.06	-.01	.20	.10
CPV Harmfulness	→	Binge-eating	.06	.06	-.05	.18	.25
Pathological identity	→	Restriction	.07	.06	-.04	.18	.20
Pathological identity	→	Binge-eating	.40	.05	.31	.50	.00
Indirect effects							
CPV Harmfulness	→	Restriction	.02	.02	-.01	.06	.20
CPV Harmfulness	→	Binge-eating	.12	.02	.08	.17	.00
Total effects							
CPV Harmfulness	→	Restriction	.11	.54	.01	.22	.03
CPV Harmfulness	→	Binge-eating	.18	.57	.08	.30	.00

Note. Values reported are standardized.

[a]95% confidence bounds

The Moderation Hypothesis

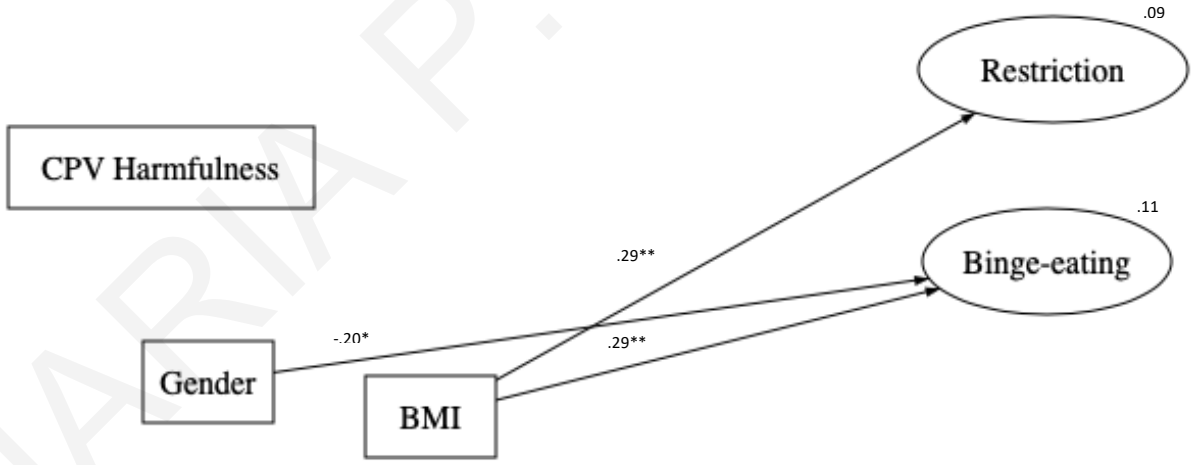
Moderation of emotion dysregulation was examined using multi-group SEM analysis. Two models were examined simultaneously for individuals reporting high or low emotion dysregulation. Initially, an unconstrained model was examined to determine whether it

demonstrated a good fit for each group. Path coefficients were freely estimated without any equality constrain. Results indicated that the unconstrained model demonstrated an adequate fit to the data for individuals reporting high emotion dysregulation (clinical range) [χ^2 (81) = 171.66, p < .001; CFI = .92; TLI= .89; RMSEA= .07; SRMR = .06], and for individuals reporting low emotion dysregulation [χ^2 (81) = 144.20, p < .001; CFI = .90; TLI= .88; RMSEA= .07; SRMR = .08]

Next, the unconstrained model was examined with both groups simultaneously and presented an adequate fit of the data [χ^2 (162) = 315.92, p < .001; CFI = .91; TLI= .89; RMSEA= .05; SRMR = .08]. The structural parts of both models (high and low emotion dysregulation) can be seen in Figure 4 and Figure 5.

Figure 4

Structural Equation Model (Moderation Model; High Emotion Dysregulation) Predicting DEBs from CPV Harmfulness

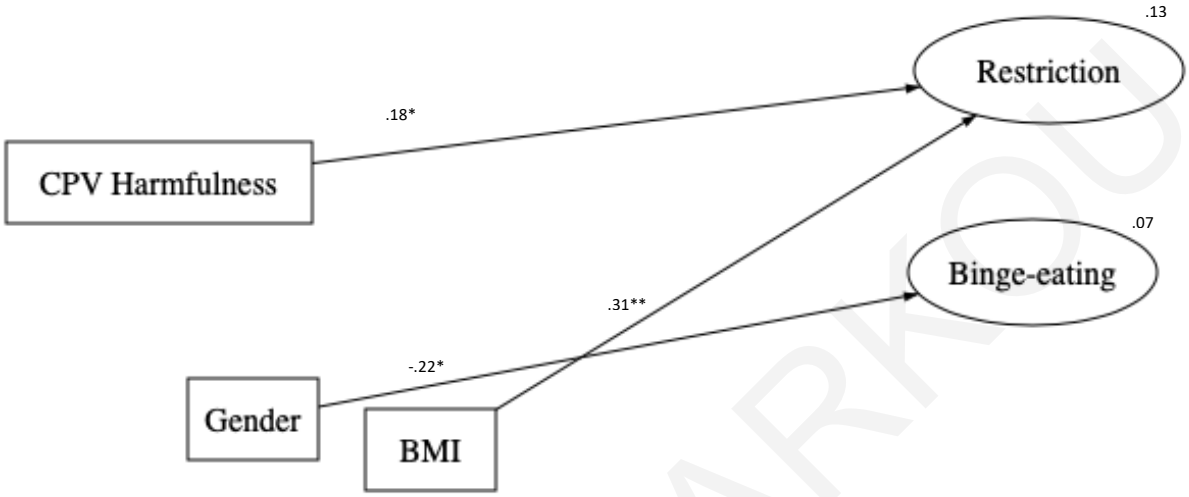


Note. All coefficients shown are standardized. Only significant effects are presented. Values placed over the endogenous variables represent squared multiple correlations.

*p ≤ .05, **p < .001

Figure 5

Structural Equation Model (Moderation Model; Low Emotion Dysregulation) Predicting DEBs from CPV Harmfulness



Note. All coefficients shown are standardized. Only significant effects are presented. Values placed over the endogenous variables represent squared multiple correlations.

*p ≤ .05, **p < .001

One potentially moderated effect was indicated. The effect of CPV harmfulness on restrictive eating was statistically significant ($p < .05$) only for the group who scored low on emotion dysregulation.

To examine this potentially moderated effect, a new multi-group model was examined in which the effect of perceived CPV harmfulness on restrictive eating was constrained to be equal across both groups. Results showed that this model had an adequate fit for the data [χ^2 (164) = 321.65, $p < .001$; CFI = .91; TLI= .88; RMSEA= .05; SRMR = .08]. The chi-square difference had a value of 5.73 [$\Delta\chi^2$ = (321.65-315.92) = 5.73] for 2 degree of freedom. This value was not significant ($p > .05$), indicating that the constrained model did not significantly degrade model fit relative to the unconstrained model. This finding suggests that the effect of

perceived CPV harmfulness on restrictive eating behaviours did not differ between the two groups and therefore moderation of emotion regulation difficulties for this effect could not be assumed.

Qualitative Phase

Interpretative Phenomenological Analysis of the six semi-structure interviews revealed two superordinate themes. These themes along with their subordinate themes and the participants that contribute to each are presented in Table 4.

To keep with the idiographic focus of IPA, each theme is presented by discussing each participant in turn.

Table 4

Superordinate and Subordinate Themes Along with Participants Contributing to each

Superordinate theme	Subordinate theme	Participants
Causes and triggers for current DEBs	DEBs experienced as a response to negative affect	All participants
	DEBs experienced as a response to perceived lack of control	DK
	DEBs experienced as a consequence of growing up in a diet conscious environment	PA, EZ, DK
	DEBs experienced as a consequence of CPV experiences:	PA, EZ, TP, PG, DK
	- Living with an unwanted sense of self	PA, EZ, PG
	- Body dissatisfaction	EZ, TP, PG
Functions and Maintaining mechanisms of DEBs	DEBs as an emotion regulation strategy:	
	- Binge-eating as a distraction that helps cope	PA, RI, DK
	DEBs experienced as enjoyable	PA, EZ, PG, RI

DEBs provide sense of identity	PA, DK
Restriction provides sense of control	TP, PG, DK
Restriction provides sense of self-confidence	EZ, PG, DK
External positive comments about appearance and weight	PG, DK
Restriction as a way to elicit concern from significant others	PG
Sense of being powerless to stop DEBs	PA, EZ, TP, RI, DK
Distorted beliefs	EZ, TP, PG, DK

Theme One: Causes and Triggers for DEBs

The first superordinate theme that emerged from the narratives focused on how participants make sense of their current DEBs; what they believe contributed to the development of their current DEBs and on the factors that trigger them. Within this theme, four subordinate themes were identified: 1) DEBs as a response to negative affect, 2) DEBs as a response to perceived lack of control, 3) DEBs as a consequence of growing up in a diet conscious environment, 4) DEBs as a consequence of CPV experiences including: a) living with an unwanted sense of self and b) body dissatisfaction.

PA - PA describes that his binges are triggered by *negative emotions*: "When I have a bad day, I will binge once I get home". In his account he explains that "a bad day is when something bad had happened at work or I had an argument with my girlfriend, or I just woke up feeling depressed and like crap without any specific reason". In this quote it appears that PA understands his binge-eating as a result of negative emotions triggered by different

negative situations. PA also mentions contextual triggers such as night-time and when at home.

He also explains that having more freedom to eat what he wants when he moved out of his family house contributed to the development of his binge-eating behaviour. He describes: "Now that I live alone and have more freedom to eat whatever I want I find myself binge-eating a lot". This is perhaps related to his long history of dieting and having to follow specific rules around food during his childhood that were imposed both by his family (i.e., *diet conscious environment*) and different dieticians that he visited. For instance, he mentions that "from a young age they kept taking me to different dieticians, so I always had foods that I was allowed to eat and foods that I wasn't allowed to eat. I've always had someone watching and telling me to avoid specific foods". Although not explicitly linked by PA, his binge-eating could partly be a result of his history of dieting and food restriction when young.

PA also talks about feeling guilty when eating something unhealthy as a trigger for his binge-eating. This is perhaps related to the *diet conscious environment* that he grew up in and the belief that there are only certain foods that he can eat. Thus, it seems that when PA eats something that is not under the specific foods that he believes he can eat he feels guilty and that triggers his binge-eating behaviour.

PA also describes how from a young age he internalised the belief that he is fat: "I've always thought of myself as being the fat one…always…even when I wasn't overweight". His account reflects a merge of his weight and his identity and this belief was reinforced by his environment (e.g., family and peers). He talks about various critical comments he received from family members about his weight and physical appearance when he was young and how these comments affected the way he views himself: "Everyone from my family commented on my weight. Even my grandmother that didn't see me as frequently she always commented on my weight and this made me feel bad…it's very difficult when someone from your family that

hasn't seen you for a long time the first thing they would say to you is something about your physical appearance and your weight".

PA also describes experiencing CPV from a young age, mainly negative comments and social exclusion due to his physical appearance and weight. These experiences, along with growing up in an environment that focused on his weight and physical appearance, served to strengthen his sense of not being accepted by others due to his weight. He also describes how these CPV experiences have affected the way he experiences himself now demonstrating the enduring influence of CPV. For instance, in response to the question of whether he believes CPV experiences had any impact on his life now, he responded: "Being a victim of bullying had a great impact on how I perceive myself. If I haven't experienced bullying, I would feel better about myself and I would think in a more positive way about myself. I've always considered myself as a loser and fat". This account demonstrates that PA experiences himself in a negative way and that he attributes this negative self-perception to the CPV experienced when young.

The fact that he talks about being fat when asked about self-perception also reinforces the idea that he considers his weight as part of his identity. Equating his identity with his weight could partly explain the experience of living with an *unwanted sense of self* that is depicted in his accounts when talking about his experiences. Moreover, his experiences of social exclusion during his childhood due to physical appearance, weight-related comments from family and peers, in addition to being taken to different dieticians to control his weight at that time may have led to the development of the belief that being overweight is a problem that needs to be fixed in order to be accepted by others. All these experiences seem to have acted as predisposing factors in the development of his binge-eating behaviour that, as will be discussed later, currently serves as a coping mechanism.

EZ - Like PA, EZ describes growing up in a *diet conscious environment*: "Everyone in my family was somewhat following a specific diet to lose weight". Unlike PA, however, she explicitly attributes her current DEBs to the environment that she grew up in that included critical comments about her weight and physical appearance from family members and *CPV experiences*: "when you have someone commenting and making fun of who you are, your weight and your appearance in general, those memories stay with you as a voice in your head affecting you". In her description she also talks about her efforts to control those "voices" and how those experiences affect her current mental health: "I still cry when I think about what I went through". Her account shows the enduring influence of CPV on her current mental health. These experiences according to EZ contributed to her current DEBs by making her focus more on her physical appearance and weight: "Those experiences when young changed the way I perceive myself, they made me focus on how I look, my body and my physical appearance. I wouldn't think of myself in the same way if I didn't have those experiences". She then goes on and explains: "Sometimes while I'm watching TV there could be girls that are half my weight in the show and then I see myself and I feel bad about the way I look and so I make a commitment with myself that I won't eat again…and this can last for several days". She also mentions: "When I see others that are thinner than me, I start feeling bad about myself and so I tell myself that I won't eat again". Her descriptions also show frequent engagement in weight/appearance comparisons. While not directly stated, EZ expresses *body dissatisfaction* as a result of those comparisons that trigger her restrictive behaviours.

The quotes mentioned above also suggest that as a result of CPV experiences, EZ lives with an *unwanted sense of self* that triggers her restrictive behaviour. Later in the interview she talks again about a negative view of herself and how this triggers her restrictive eating but in a more coherent way. For example, she describes: "Some of the thoughts that I have that trigger my restrictive patterns is when I see someone thinner than me and I have the thoughts: why

am I like this? Why am I not like them? I could be like them…everyone says that it would be better if I were like that…how can I be like this? and then I start hating myself and so I don't eat".

Negative affect is described as a trigger for EZ's binge-eating: "When I am depressed…I binge". Same as PA, she also mentions contextual factors that trigger binge-eating such as after work and when she is in her house. EZ also describes binge-eating as a response to physical triggers such as hunger.

The analysis suggests that EZ understands various factors as contributing to her restrictive and binge-eating behaviour, including negative affect, the family environment that she grew up in and the CPV that she experienced. EZ's account suggests the presence of enduring consequences of the CPV experiences, such as her unwanted sense of self and body dissatisfaction, that in turn trigger restrictive eating patterns.

TP – TP understands her restrictive behaviour as a result of two different experiences. Initially she describes her restrictive eating patterns as a response *to negative affect*, mainly anxiety and psychosomatic pain in the stomach that is a result of feeling stressed. More specifically, she describes: "Restriction is clearly a response to feeling stressed. When I get extremely stressed, I get this pain in my stomach and I stop eating". She then goes on and explains that when she gets really stressed her mind starts playing "games" with her and so she experiences body image distortions, mainly about her waist, that trigger her restrictive eating patterns. In her account, she describes internalizing the belief that there is something wrong with her appearance when she was younger, which is why she started restricting. She explicitly attributes restriction to the *body image concerns* that she experiences that were caused by *CPV experienced* in primary school, demonstrating the enduring impact of CPV:

"The body image concerns that I have are a result of the bullying that I experienced during primary school. It's like I got brainwashed and acquired a wrong image of myself".

The use of the word "brainwashed" in the quote above is very informative and suggests that CPV was an experience that was understood by TP to have had a significant impact on her current view of self and her eating behaviours. TP describes that in situations where she feels stressed, she becomes more vulnerable to the "games" of her mind that create a distorted image of her body that leads to restriction. Interestingly, TP also frames the psychosomatic stomach pain as part of the "game" that her mind plays with her to make her restrict and thus a trigger for her restrictive behaviour. Across the interview, TP shows a clear understanding of the triggers of her restrictive behaviour. There is also a hint that TP is trying to manage her DEBs by externalizing her eating-related and body-image related intrusive thoughts. This is evident in her account where she uses sentences like: "it's part of the game of my mind", "my mind tries to make me restrict", "I try to not let my mind win", "I know that everything is part of my mind playing tricks on me".

Unlike PA and EZ she makes no mention of her family and describes growing up in an environment where no one was worried about their diet or weight.

PG – PG describes a sudden interest in veganism that started during a stressful period in her life as an instigator for her restrictive eating: "My interest in veganism started during a very stressful period in my life, when I was studying for the Pancyprian exams". This quote indicated that PG attributes the development of her restrictive eating to stress related to school. Although not explicitly stated, PG's narrative suggests that she used veganism to mask restrictive eating: "First, I started cutting out foods from my diet that were considered non-vegan and that was ok, but then gradually I stopped eating other foods that were considered vegan", "I was eating very little portions…I was trying to eat as little as possible and at some

point I lost a lot of weight". She also describes engaging in different compensatory behaviours during that time including excessive exercising.

PG also describes that she frequently engages in binge-eating and discusses *negative affect* as a trigger. More specifically, it seems that PG associated binge-eating with stress: "When I feel anxious, I eat and eating is the only thing that I want to do at that moment".

Although PG does not directly attribute her current binge-eating or restriction to the *CPV experienced* when young, when asked, she describes that from a young age she didn't like herself and that CPV experiences during primary school reinforced those negative feelings that she had about herself. She describes engaging in frequent weight and physical appearance comparisons during that period of her life: "I was comparing myself to others and was feeling bad for not having the same thin body…I didn't like myself". While not directly stated, PG expresses *body dissatisfaction* as a result of those comparisons that could have instigated her restrictive behaviour. The quote mentioned above also suggests that PG was living with an *unwanted sense of self* that was reinforced by CPV experiences. This unwanted sense of self may have contributed to her current disordered eating patterns. Unlike EZ and PA, PG does not talk about any feelings related to her sense of self at present.

RI – RI describes her binges as a response to *negative emotions*. Specifically, she talks about anxiety and sadness: "when I have those thoughts, mainly about the future, I feel anxious and so I binge". RI also identifies contextual factors as triggers for her binge-eating, such as being at home alone: "Basically…when I am not feeling well emotionally, I prefer to stay at home…and when I am at home I binge". The notion that RI's binges are triggered by negative emotions is also implicit in this quote. When she feels sad, she isolates herself, which triggers her binge-eating.

RI understands her binge-eating as being a result of an intense feeling of emptiness and sadness that she was feeling when she moved to another city and realized that she lost her friends. In her narrative, losing her friends was equated as having lost an important part of her identity, which led to intense sadness and binge-eating in the years that followed: "My issues with food started when I moved to another city and I realised that I lost my friends", "Losing my friends felt like I've lost a part of who I am. Basically, I've changed as a person after that…it's difficult for me to make new friends or trust anyone. I miss my old self". Although not directly stated, sadness seems to be a trigger for her binge-eating. Also, implicit in the quote mentioned above is the notion that RI *dislikes herself now* and prefers her old self. This, indirectly, could trigger her binge-eating as she could be using binge-eating to escape from the distress associated with negative thoughts about her identity. This is discussed further in the following theme.

Unlike PA and EZ, RI denied that the CPV that she experienced when young has influenced her current eating behaviour in any way and describes having a healthy relationship with food when she was young.

DK – DK attributes her restrictive behaviour to a *perceived lack of control* that she experienced in various situations when she started going to the university. Specifically, she says: "I think that my restriction and obsession with food started when I was feeling an intense need to gain some control over different situations in my life. At the time when I started restricting, we had some family issues…I was experiencing a lot of stress at university…I was feeling lost with all the new things that I had to face…and I believe that this chaos that I was feeling in my life led to a need for control and restricting food gave me this".

She also states that meeting new people at university prompted her restrictive eating: "It's when I went to university and started meeting new people that restriction became more

apparent. I started losing weight and everyone was giving me compliments for my appearance…this is when my restriction began, I think". Her narrative suggests that meeting new people was a situation that prompted her restrictive behaviour. In this quote, implicit is the idea that meeting new people is an anxiety-provoking situation for DK who might feel that she doesn't belong or that she is not accepted by others. This is probably related to her *history of CPV*, repeated exclusion specifically. However, when she was asked directly whether she believes that her CPV experiences have affected her current eating behaviours she denied this. When she started losing some weight, people started commenting on her appearance in a positive way. This transformed into an intense desire to keep low weight, prompting restrictive eating.

DK also describes that she sometimes binges when she feels anxious, suggesting that like the other participants *negative affect* triggers her DEBs.

Based on her narrative DK does not seem to understand her DEBs as an outcome of the environment that she grew up. However, when asked, she describes growing up in a *diet conscious environment*: "My mum was always worried about her weight and was always on a different diet to lose weight. The food that she was cooking was, most of the times, carefully prepared, according to her diet".

Theme Two: Functions and Maintaining Mechanisms of DEBs

In analysing participants' narratives, it was clear that DEBs serve a highly functional role in their lives. Theme two, therefore, focuses on participants' understanding of their DEBs as functional and the reasons that they believe they continue to either binge-eat or restrict.

Within this theme, nine subordinate themes were identified: 1) DEB as an emotion regulation strategy, 2) DEBs experienced as enjoyable, 3) DEBs provide sense of identity, 4) Restriction provides sense of control, 5) Restriction provides sense of self-confidence, 6) External positive comments about appearance and weight, 7) Restriction as a way to elicit

concern from significant others, 8) Sense of being powerless to stop DEBs, 9) Distorted beliefs.

PA – PA understands that his binge-eating functions as an emotion regulation strategy. More specifically, for PA binge-eating appears to *serve as a distraction* that helps him cope. He specifically reports that when he binges, he is able to ignore all negative thoughts, including thoughts about the consequences of binge-eating: "When I binge, I'm not thinking about anything else, not even about the regret that I would feel after the binge ends". He also compares binge-eating with other strategies that he uses to distract himself: "Sometimes when I am not feeling well, I also play video games to distract myself from those thoughts or other times I play music or watch YouTube videos again to distract myself. I always do this, distracting myself when not feeling well".

Of note is what PA describes when asked about why he thinks he uses distraction strategies to cope: "I think all those distraction strategies when I am not feeling well help because I am doing something that distracts me from reality…and so I don't think about anything else at that time". The use of the phrase "distract from reality" is very informative and suggests that PA uses distraction strategies to help him escape reality. This could suggest that binge-eating, which serves the same function as the other strategies described (i.e., distraction), helps him escape reality by narrowing his focus on what he is eating and thus distracting him, in the short-term, from negative emotions.

Thus, it seems that, for PA, binge-eating is a useful technique that he uses to cope with difficult thoughts and emotions. This also suggest that PA experiences some difficulties in regulating his emotions and more specifically in using effective emotion regulation skills. As it appears in his narrative, currently, his main emotion regulation strategy is avoidance of intense emotions, including distraction, to cope with intense emotions.

PA also talks about the feeling of *enjoyment* he gets from eating unhealthy and tasty food. He mainly describes a positive feeling of enjoyment during binge-eating that changes into guilt as soon as he stops: "at that moment I know that I'm full, but I can't stop eating because I like the food that I'm eating, I enjoy the taste of whatever I'm eating, but then, after I stop bingeing, I start having those thoughts that I shouldn't have done it".

He acknowledges that he experiences positive change in his mood from binge-eating: "when I am having a bad day, eating helps lift my mood". However, PA doesn't explicitly make the connection that the positive feeling of enjoyment that he experiences during the binge in part maintains his binge-eating behaviour. Moreover, as mentioned above, binge-eating for PA is used as an *emotion regulation strategy* to help him "escape" reality. Binge-eating, thus, provides PA with an emotional escape, which contributes to the maintenance of his bingeing behaviour.

Throughout his narrative, PA expresses hopelessness and *powerlessness* when talking about his eating difficulties: "I always felt fat…there was never a time in my life that I didn't think of myself as being the fat one…it's like I know that I will always be like that…whatever I do". The repeated use of the word "always" indicates PA's sense of hopelessness in changing his current situation and more specifically the view of himself as being the fat one. In his narrative he also describes many failed attempts in controlling his eating difficulties that contribute to his *sense of powerlessness*: "I try to eat healthier, legumes and stuff, but then when I get home after work it always ends the same way, I will order a lot of food and I will binge. I always try to control my binge-eating, but I always fail". This sense of powerlessness seems to act as a barrier in his efforts to control his binge-eating behaviour, contributing to the maintenance of this behaviour.

Moreover, as mentioned under theme one, PA seems to have merged his weight with his identity. So, although not explicitly stated by PA, losing weight could be considered as a

threat to his identity. Binge-eating thus gives him and helps maintain, this *sense of identity* that he equated from a young age with his weight.

EZ – EZ explains that restrictive eating provides her with a goal that she can achieve: "I want to restrict because it gives me something to aim for and it also helps me reach my goal". Thus, for EZ, restrictive behaviour provides her with a sense of achievement that seems to contribute to her *sense of self-confidence*.

EZ describes that both restriction and binge-eating are useful in helping her cope with negative emotions: "It's not that I want to binge, it just makes me feel better". She also describes that restriction helps regulate negative feelings in relation to her physical appearance, as well as feeling of guilt related to her binge-eating. Like for PA, DEBs for EZ function to improve her mood and regulate negative affect, thus acting as a maladaptive *emotion regulation strategy*. Also, like PA, EZ acknowledges that she experiences positive mood change when she binges or restricts. She talks about the positive feeling of *enjoyment* associated with both restriction and binge-eating, but more specifically, when talking about the feeling of enjoyment associated with binge-eating she explains that the act of chewing at the moment of binge helps improve her mood. Binge-eating and restriction for EZ thus seem to be useful in helping her cope with negative emotions. The positive feelings associated with her DEBs could be maintaining her DEBs.

The analysis also suggests that EZ recognizes that the positive effects of binge-eating are only short-term and that it could potentially affect her in a negative way, yet she is reluctant to engage with this knowledge: "I know that this isn't good for me but even for that short period of time that I'm able to control myself and restrict, it makes me feel good even if I know that it's not good for my body". Her account suggests that her eating behaviour is guided by pleasure-seeking. Moreover, in the quote above, EZ seems to experience a *sense of*

powerlessness over her eating behaviour. This *sense of powerlessness* over her eating behaviour is also depicted in the quotes that follow from EZ's narrative:

- "during a binge I can understand that I ate too much and that I need to stop but I can't control it"
- "Sometimes I just can't stop eating. I could start with one food, then continue with another and another…something like that"

Here, EZ describes the compulsive nature of her binge-eating and a *sense of powerlessness* in resisting the urge to binge.

EZ also makes a number of statements that indicate *distorted beliefs* that may perpetuate her DEBs. For instance, she makes several statements that imply distorted beliefs about the consequences of eating. More specifically, the belief that eating can cause immediate weight gain is evident when she talks about the need to compensate after eating: "Sometimes when I binge, I feel bad about my weight, I stop eating and this can last for several hours or even for a whole day". This quote also suggests another distorted belief that may perpetuate the compensatory behaviour (i.e., restriction) of EZ: the belief that by not eating, one can reverse the effects of binge-eating.

TP – Controlling her food and body weight provides a *sense of control* for TP who otherwise feels out of control. TP has a long history of physical problems from a young age. These problems may have contributed to feelings of anxiety and of being out of control, especially over her body. Restricting her food thus gives her this sense of control that she desires. TP also mentions that restriction helps control anxious feelings and decreases her physical pain and thus functions as a strategy to control her pain: "The psychosomatic reaction to stress that I have, which is pain in my stomach, is not something that I can control, it's

automatic and I also have concerns over my body and appearance. So, restricting helps me manage not only the physical pain but also eases the anxiety that arises from my body image concerns".

In TP's narrative, it also appears that she is confident in her ability to manage her eating difficulties, yet the words that she uses when describing these show a *sense of powerlessness* over her eating difficulties that may be perpetuating her DEBs. For instance, she describes: "It's like I am in a constant fight against my mind, always trying to not let it win…it's very tiring". Her *sense of powerlessness* over her eating difficulties is supported by her account on feeling compelled to restrict: "I wanted to eat but at the same time I felt that I couldn't eat and that I needed to restrict, so I didn't eat".

TP, as mentioned in theme one, describes internalizing the belief that there is something wrong with her appearance and that she was fat when she was younger. Despite that she now realises that there is nothing wrong with her appearance, there are still times that she is convinced that her appearance is flawed, specifically her waist and that she needs to restrict in order to "fix" it: "Sometimes I get obsessed with my waist and abs, even if I know that my waist looks great, my mind is insisting that there is something wrong to make me restrict". The hyper focus on her waist and her *distorted beliefs* about her appearance, are in part maintaining her restrictive behaviour.

Overall, TP's understanding of why she restricts seems to be coherent. Her account suggests that she acknowledges that her distorted body image and beliefs about her body is what maintains her restrictive behaviour. Unlike other participants who restrict, when talking about restriction there is a sense that she wants to stop doing it: "Sometimes I understand that it's my mind that is playing tricks on me to make me restrict and so I do the exact opposite because I don't want to please it". Thus while, as mentioned above, she describes restrictive eating as a "battle with her own mind that she is constantly fighting and trying to win"- that

depicts a sense of powerlessness- it is evident that she has a clear understanding of the factors that perpetuate her eating difficulties.

PG – For PG, restriction functions as a way to *elicit concern* from significant others. When she started restricting food and changing her diet people around her showed interest and started commenting on her new behaviour. PG used the word "attention" when describing these experiences, which shows that she interpreted those comments and interest from others as gaining attention: "I liked the attention that I got from my friends. When I started restricting and eating only specific foods they were interested and kept asking me how I managed to lose weight and they were interested in the types of food that I was eating, and this felt nice". Losing weight, as a result of restriction, also *elicited concern*, especially from her mother: "my mum got very anxious when I started losing weight and so she took me to a dietician to help me put on weight. She was also worried and always asking why I wasn't eating specific foods". It seems that restriction provided PG a sense of love and concern from other people that are important to her that she may have not experienced in the past.

Related to the above, PG describes: **"**When I first lost weight, my friends started commenting on my appearance and started giving me more attention and I liked that, everyone was asking how I managed to lose weight"**.** In this quote, PG talks about receiving *positive feedback* from others. The way that she talks about the attention and concern she receives from significant others suggests that she experiences these comments and concerns as positive and can thus be considered as important factors in maintaining her restrictive behaviour.

PG's restrictive pattern could also potentially be perpetuated by her *distorted beliefs* that restriction, in particular following a specific low-calorie diet, is good for her health and can help elevate her mood. Along with these beliefs, several other distorted beliefs were identified in her narrative including the belief that specific foods can cause immediate weight

gain, which led to the development of fear around such food, (i.e., "I avoid eating bread, olive oil, fried food") and the belief that she needs to follow specific rituals to be able to eat including the need to exercise for specific amount of time and the need to weight food before eating. Such beliefs could justify her restrictive eating.

In addition, PG describes that restriction gives her a *sense of control*: "When I'm feeling stressed about different things in my life and feeling out of control, controlling what I eat makes me feel that I am in control of my life and that I have more self-discipline, which I can then apply to other areas in my life such as studying". This quote also suggests that controlling her food (i.e., restricting) also contributes to her *sense of self-confidence* and thus her ability to control other areas of her life, including her ability to focus on her studying. Restriction is thus experienced as functional by PG as it gives her a sense of inner strength and control.

She also talks about how good restriction makes her feel: "it's that wow feeling you get after not eating for several hours and seeing the lower numbers on the scale. You feel lighter and that makes you feel even better". It is clear in this quote that PG has associated restriction with positive feelings and that she *enjoys restricting her food*. These positive feelings that result from restriction are obvious factors in maintaining her restrictive eating pattern.

RI – Like for PA, RI understands her binge-eating as an *emotion regulation strategy* and more specifically as a *distraction* that helps her cope: "When I'm binge-eating, it's like a distraction for me. At the moment of bingeing, I don't have those anxious thoughts and somehow it's impossible for me to think or feel sad about anything at that moment". She later adds: "when I am not feeling well, I stay at home, and I eat. If I had something else to do that would help distract me, I would do that". This quote supports the idea that binge-eating functions as a distraction for RI that helps her cope. Like PA, it appears that distraction is her

main emotion regulation strategy, suggesting that RI has some difficulties in emotion regulation skills. In support of this, she also describes: "if I don't binge, I usually lie on the couch and that would lead to a cycle of negative thinking and sadness". From her narrative, it appears that RI understands binge-eating as her only coping strategy, which partly explains why she continues to binge.

In contrary to other participants, RI does not explicitly describe binge-eating as enjoyable, but she characterizes food as her "friend", which suggests that she has associated positive feelings with food: "I don't know how to say this…instead of going out to see my friends I prefer to stay home… food is my friend… it's what pleases me and makes me feel good…sometimes I'm not even hungry, but I do it anyway". The use of the phrases "pleases me" and "makes me feel good" support the idea that binge-eating is *experienced as enjoyable* for RI. This positive feeling of enjoyment associated with binge-eating is a factor that maintains her binge-eating behaviour.

Similar to other participants, RI discusses her struggle to control her eating behaviour that somehow conveys a *sense of powerlessness* over binge-eating: "I feel that I can't do anything about it…it's like I don't have any control over it". Furthermore, as mentioned above, RI clearly frames her binge-eating as her key coping mechanism for dealing with negative emotions by helping her escape from the negative thoughts. This uniqueness of binge-eating in controlling her negative emotions is also echoed in a later statement where she explicitly describes that she doesn't have other coping mechanisms when feeling emotionally unwell: "sometimes it's like bingeing is the only thing that helps distract myself from the negative thoughts when I'm home and not feeling well". The *sense of powerlessness* over her eating in addition to the idealisation of binge-eating as her only effective coping mechanism are factors that perpetuate her binge-eating behaviour.

DK – DK admits that restriction provides her with a *sense of control*: "Basically, I believe that restriction gives me this sense of control. Ok I'm not saying that I am a control freak but for example you may have a situation in your life that you don't know how to handle and so controlling your food definitely makes you feel better".

She then goes on and describes: "Because I am the one that decides the specific rules to follow, I feel in control". While these quotes suggest that restriction provides DK with a *sense of control*, which is a factor that maintains her restrictive behaviour, when she goes into further detail about her restrictive behaviour it seems that it also gives her a *sense of self-confidence*: "Hunger is something I know how to do, and I'm good at it, I do it well and this feels good". Restriction is seen as a success for DK. The feeling of being capable and successful in controlling her food adds to her self-confidence, maintaining her restrictive behaviour. Restriction also gives her the opportunity to receive *positive comments* from others about her appearance that also help improve her *self-confidence*. As also mentioned under Theme one, her restrictive eating begun as a goal-directed weight loss behaviour. However, when she started losing weight, people started commenting on her low weight and appearance, giving her positive feedback leading to an intense desire to keep at low weight: "I reached a point where I started losing weight and I wanted to lose even more because of the comments that I got from others that were like this: Wow you lost weight, you are looking great and much prettier now. And comments like these feel good"

The use of the words "feel good" depicts the rewarding nature of the *positive comments* about her weight, suggesting that such positive comments could be maintaining her restrictive behaviour. The compliments and *positive comments* about her appearance also seem to be of high importance to DK and she describes being afraid of the negative comments that she might receive if she puts on weight: **"**I have this fear that if I stop restricting, I will put on weight and others will comment on that and I will feel bad for putting on weight". Controlling

her food through restriction therefore seems to help her stay in control over her weight and thus in control over her feelings, reinforcing her restrictive behaviour.

Some of DK's statements also indicate that restriction is part of her identity. Although not directly stated, implicit in the quote that follows is the notion that DK is afraid that if she stops restricting, she will lose a part of herself. "Restriction gives you this sense that you are still yourself in a way because you have control over what you are eating and it's like you have control over who you are". It can therefore be inferred that restriction for DK provides a *sense of personal identity* that she would otherwise not have.

She also describes that sometimes she binges to cope with stress. She specifically explains: "I feel that eating is something I do to escape from the stress that I'm feeling…I don't know how but when I binge, I don't feel anxious at all, bingeing really helps". The use of the word "escape" suggests that, like in other participants, binge-eating for DK seems to function as an *emotion regulation strategy* and more specifically as a *distraction* that helps her cope with anxiety.

DK also made a number of statements that imply *distorted beliefs* that may perpetuate her DEBs. For example, she talks about having to eat at specific times every day, having to count calories at every meal and having to exercise for a specific amount of time. She describes how all these rituals became something she did and felt that she needed to do: "automatic". She then goes on to describe how she felt trapped and *powerless* to stop them: "I reached a point where I was counting all the calories in every food that I was eating, and it felt like I couldn't not escape from this thing". These rituals around food reflect several *distorted beliefs* she may have that may perpetuate her DEBs. Examples of possible distorted beliefs reflected in her account include:

- The belief that specific foods can lead to immediate weight gain and thus should be avoided

- The belief that catastrophic outcomes may occur if she doesn't complete her ritualistic behaviours (e.g., unless I don't restrict/exercise I will gain a large amount of weight)

The rituals that lead to restrictive eating described above are helping DK feel in in control and this *sense of control* that is gained from these rituals could be a perpetuating factor for her restrictive eating.

Chapter Six: Discussion

The present thesis is one of the first that uses a mixed method approach to examine the relationship between CPV harmfulness and DEBs in emerging adulthood. This was achieved in two phases. In phase one, the role of pathological identity development and emotion regulation abilities in the relationship between CPV harmfulness and DEBs was examined using self-report data. A subset of participants from the sample of phase one was then selected for phase two. Phase two focused on examining how emerging adults with a history of CPV interpret their experiences with DEBs using qualitative data. Phase two complemented the quantitative data from phase one by obtaining insights into participants' current experiences of DEBs.

The analysis from phase one indicated significant direct effects of CPV harmfulness on DEBs. Findings also supported the indirect relationship between CPV and binge-eating through pathological identity development. In addition, moderation analysis revealed that the effect of CPV harmfulness on DEBs was the same across both groups, high and low emotion regulation difficulties, suggesting that difficulties in emotion regulation did not moderate the relationship between CPV and DEBs in the present sample. In phase two, participants' current experiences with DEBs were captured in two superordinate themes: 1) Causes and triggers for DEBs, 2) Functions and Maintaining mechanisms for DEBs.

Results for both phases in relation to existing literature are discussed separately in the following sections. Limitations, contributions to current research and recommendations for future research are also discussed under each section. Finally, there follows a discussion on how results from both phases relate to each other.

Quantitative Phase

As expected, the findings of the present thesis indicated that the harmfulness of the CPV experience significantly predicted both binge-eating and restrictive eating in emerging

adulthood. A unique characteristic of the present thesis was the use of the concept of harmfulness of the CPV experiences instead of the mere exposure to CPV as in previous literature. Harmfulness is conceptualised as the by-product of both frequency and the perceived intensity of the CPV experience (Volk et al., 2014). Comparison of the present findings with those of other studies that used retrospective reports of CPV experiences reveal similar findings (Agras, Bryson, Hammer, & Kraemer, 2007; Engstrom & Norring, 2002; Striegel-Moore et al., 2002; Frank & Acle, 2014), providing further support for the relationship between CPV and the development of DEBs later in life. While preliminary, the present findings suggest that the harmfulness of the CPV experience could be a significant predictor of both restrictive and binge-eating behaviours in emerging adulthood and provide a useful conceptualization for investigating the interaction among CPV experiences and the development of DEBs in future studies.

In terms of the role of pathological identity development in the CPV harmfulness-DEBs relationship, the present thesis found support for the indirect relationship between CPV harmfulness and binge-eating through pathological identity development. However, the indirect relationship between CPV harmfulness and restrictive eating was not supported. Identity development, thus, seems to be a significant factor through which the effect of CPV harmfulness on binge-eating in emerging adulthood occurs. Accordingly, it is possible to hypothesize that harmfulness of the CPV incidents can affect the development of an integrated identity, which in turn can predict the development of binge-eating in emerging adulthood. In a period where many challenges exist (Arnett, 2002) and concerns about physical appearance and social acceptance increase (Godina & Zadorozhnaya, 2016; Harter, 1999; Senin-Calderon, Rodriguez-Testal, Perona-Garcelan, &Perpina, 2017) it appears that not having an integrated identity, due to having experienced harmful CPV, can increase the risk of internalizing social

standards about weight and appearance, which can in turn make these individuals more vulnerable to adopt DEBs (Vartanian, 2009).

In accordance with the literature, binge-eating helps individuals avoid dealing with identity issues and "escape" from the negative thoughts associated with the self (Heatherton and Baumeister, 1991; Polivy, Herman, & McFarlane, 1994). Thus, it could be that binge-eating in emerging adults who have experienced CPV could function as a coping mechanism that helps them deal with identity issues that have resulted from harmful CPV experiences. These findings are also consistent with previous evidence indicating an indirect effect of CPV on DEBs (e.g., Hawker & Boulton, 2000; Troop-Gordon & Tapp, 2005) and provide a new perspective on the pathway through which CPV experiences can affect the development of DEBs in emerging adults. Despite the theoretical and empirical support of the present findings, the analysis is based on cross-sectional data and therefore cause-and-effect inferences should be interpreted with caution. Longitudinal data is recommended to provide additional support for the present findings. Limitations in regard to the cross-sectional data are discussed below in more detail.

The present study also incorporated difficulties in regulating emotions as a moderator of the relationship between CPV harmfulness and DEBs. Contrary to expectations, the results of the moderation analysis demonstrated that difficulty in emotion regulation did not moderate the relationship between CPV harmfulness and DEBs. Low levels in emotion dysregulation did not act as a protective factor against DEBs in the present sample. A possible explanation for this result is that perhaps the ability to regulate ones' own emotions is not as important in restrictive eating and binge-eating in emerging adults with a history of CPV as originally proposed. As mentioned in the introduction, theoretical models of eating pathology emphasise the role of DEBs in regulating negative affect (e.g., Bruch, 1973; Fairburn, Shafran, & Cooper, 1999; Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman,

1985). Similarly, qualitative studies on DEBs and emotion regulation indicate that DEBs are mainly described by individuals with EDs as mechanisms that help manage and alleviate negative emotions (e.g., Fox, Larkin, & Leung, 2011; Nordbo, Espeset, Gulliksen, Skarderud, & Holte, 2006). Without invalidating individuals' experiences from such studies, the present data suggests that in emerging adults with a history of CPV, the level at which someone has deficits in emotion regulation does not affect whether they will develop DEBs in emerging adulthood. If individuals experienced harmful CPV, they are more likely to either restrict or binge-eat when they reach emerging adulthood, regardless of their capacity to regulate their emotions.

The reason for this finding is not clear but it may have something to do with other factors that are more relevant in emerging adults with a history of CPV. In one study examining the relationship between EDs, experience of trauma, and psychosocial resources, they concluded that individuals with ED who have experienced trauma in the past could benefit from interventions that include personal resources, such as social support (Tagay, Schlottbohm, Reyes-Rodriguez, Repic, & Senf, 2014). Social support has indeed been shown to act as a protective factor and buffer against poor mental health outcomes following a traumatic event (e.g., Holt, Buckley, & Whelan, 2008). This may illuminate a possible reason why, in the present study, difficulties in emotion regulation abilities did not moderate the relationship between CPV experiences and the development of DEBs in emerging adulthood. Although decreased capacity in regulating emotions may increase the likelihood that an individual may use DEBs to alleviate negative emotions (e.g., Bruch, 1973; Fairburn, Shafran, & Cooper, 1999; Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman, 1985), not having social support during emerging adulthood may have a similar effect in individuals with past trauma experience, such as CPV. This is especially relevant in emerging adulthood were social relationships grow in importance (e.g., Larson, Whitton,

Hauser, & Allen, 2007). Instead of perceiving difficulties in emotion regulation as direct barriers in this population, social support in emerging adulthood could be as crucial in not only helping buffer against the development of DEBs in the context CPV experiences but in also promoting the development of emotion regulation abilities (Haber, Cohen, Lucas, & Baltes, 2007; Marroquin & Nolen-Hoeksema, 2015; Zaki & Williams, 2013). Further research with a focus on social support as a moderator in this relationship is therefore suggested.

With respect to gender, females reported more binge-eating and restrictive behaviours. In agreement with earlier studies, this finding further supports the higher prevalence of DEBs in females (e.g., Støving, Andries, Brixen, Bilenberg, & Hørder, 2011; Striegel-Moore et al., 2009). In terms of the BMI, results were consistent with those of previous studies. Higher BMI was associated with higher scores on restrictive eating (Berner, Shaw, Witt, & Lowe, 2013) and binge-eating (Vogeltanz-Holm et al., 2000).

Limitations

Although the findings from the present study offer new insights in the associations between CPV, DEBs and pathological identity development in emerging adults, some limitations need to be taken into consideration.

First, the present study was based on cross-sectional data and therefore certain limitations need to be acknowledged with respect to this, regardless of the strong evidence supporting the findings. For instance, given the nature of the cross-sectional analyses it was difficult to assess the stability of the variables and how identity development is affected over time, thus no causal conclusions can be drawn. Moreover, the bidirectional relationship between CPV harmfulness and identity development was not examined due to the cross-sectional nature of the data. For the same reason, the bidirectional relationship between DEBs and identity development could not be assessed. Longitudinal data is therefore suggested as this could not only provide additional support for the present findings but could also help

expand the literature in regard to the nature of the relationship between CPV and identity and clarify whether DEBs could have an effect on identity development.

In addition, using cross-sectional data means that estimates of CPV experiences were based on participants' recollections and this gives rise to questions in regard to the reliability of participants' memories. One could argue that these accounts are subject to recall biases as they are restricted to participants' memories. However, in a review by Hardt and Rutter (2004) that examined the validity of retrospective accounts of adverse childhood experiences in adults they concluded that while memories are subject to some bias, such bias is not sufficient to invalidate a retrospective account and false positive reports are probably rare (Hardt & Rutter, 2004). In addition, it has been suggested that individuals' current psychological functioning is more closely related with their subjective interpretations of the past peer victimization experience compared to whether they were actually victimized or not (e.g., Graham & Juvonen, 1998). Furthermore, it is possible that trauma in individuals who experience psychopathology is more difficult to be forgotten and is recalled easier compared to individuals with no psychopathology (e.g., Schraedley, Turner, & Gotlib, 2002). Childhood peer victimization experiences tend to be very salient experiences for individuals. Accordingly, these experiences are most likely, well remembered. It could therefore be argued that the present study provides a coherent understanding of the relationship between past peer victimization experiences and current DEBs.

The generalisability of the present findings is also subject to certain limitations. For instance, the current study used a non-clinical population and while research on this population in this area is crucial due to the high prevalence of subclinical forms of DEBs in emerging adults (National Eating Disorder Collaboration, 2010), similar studies using a clinical sample are needed as well. Another limitation is that due to the disproportionate large number of females that took part, the present findings should be interpreted with caution.

There is some evidence suggesting that women are more willing to take part in online studies, particularly those related to health and well-being (Kilpatrick, Hebert, & Bartholomew, 2005). This could partly explain the lower proportion of males compared to females that were recruited. Equal number of males and females is recommended in similar future studies.

The study also relies on online self-report data that was collected using a convenience sampling procedure. The sample was therefore not randomly selected, which limits the generalizability of the current results to a larger population. While using online self-report measures can provide some benefits, including anonymity and collection of a large amount of data, certain limitations such as, the study being only accessible to individuals who have access to a computer and internet should be considered. Also, given that most of the questions were of sensitive nature, responses could be subject to social desirability and response bias, as well as wrongful interpretations.

Lastly, the present thesis did not assess for the presence of mental health disorder diagnoses, family adversity, or parental characteristic that may have confounded the results. Results should therefore be interpreted with caution.

Contributions and Future Research

Overall, the present study has made significant contributions to the field of CPV and DEBs. Specifically, the present study highlights the significance of CPV harmfulness in the development of DEBs in emerging adulthood. In addition, the present study emphasises the significance of pathological identity development through which harm from the CPV experiences seems to affect the development of binge-eating in emerging adults. These findings indicate that individuals who have experienced CPV that was harmful tend to experience difficulties in regard to their identity, which can lead to binge-eating behaviour in emerging adulthood. Longitudinal data, however, is required to provide additional support.

To our knowledge, this is the first study to examine the indirect effect of CPV harmfulness on DEBs through pathological identity development in emerging adulthood and provides some initial evidence for the significance of identity development as a factor that contributes to the development of DEBs in emerging adults with CPV history. However, given that the analysis was based on cross-sectional data, statements of causality made throughout this thesis should be interpreted with caution. Future research would benefit by continuing to include identity development when examining the relationship between CPV and DEBs in emerging adults and should consider using longitudinal data. Furthermore, identifying the specific elements of identity that contribute to the development of DEBs in this population would help expand on the current findings and help understand this relationship in more detail.

Qualitative Phase

The qualitative phase of the present thesis aimed to explore how emerging adults with a history of CPV interpret their experiences with DEBs and how they make sense of the CPV experiences in relation to their current DEBs. The IPA analysis of the transcripts from the semi-structured interviews with six participants revealed two superordinate themes that were labelled as: 1) Causes and triggers for DEBs and 2) Functions and maintaining mechanisms of DEBs.

The results highlight how participants with either binge-eating, restrictive eating, or both, experience DEBs as both interfering with their lives and at the same time as offering them something that is functional in a way, making their DEBs meaningful to them.

The following paragraphs discuss the two themes and how they relate to existing literature.

Theme One: Causes and Triggers for DEBs

The first theme, *Causes and Triggers for DEBs*, is concerned with what participants believe contributed to the development of their current DEBs and the factors that trigger them. Four subordinate themes were identified under this theme: 1) DEBs as a response to negative affect, 2) DEBs as a response to perceive lack of control over life events, 3) DEBs as a consequence of growing up in a diet conscious environment, 4) DEBs as a consequence of CPV experiences including: a) living with an unwanted sense of self and b) body dissatisfaction.

All of the participants talked about *DEBs as a response to negative affect*. Negative emotions that were reported included: depression/low mood, loneliness, anxiety/stress. Some of the participants also reported some contextual factors as triggering their DEBs, including specific places (e.g., being at home) and specific times of the day (e.g., at night). This finding is in line with the literature examining the triggers for DEBs. For instance, common emotional triggers for binge-eating identified in the literature include depression, anxiety, boredom, loneliness, feeling unloved and anger (e.g., Fassino, Leombruni, Piero, Abbate-Daga, & Rovera, 2003; Hudson, Hiripi, Pope, & Kessier, 2007; Torres & Nowson, 2007; Zeeck, Stelzer, Linster, Joos, & Hartmann, 2011). The findings are also in line with the theoretical models of eating pathology that emphasise the role of eating disorder behaviours in regulating negative affect (e.g., Bruch, 1973; Fairburn, Shafran, & Cooper, 1999; Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman, 1985). In addition, these findings further support previous qualitative studies that found negative emotions to precede binge-eating and restrictive eating (Heatherton, Polivy & Herman, 1990; Newman, O'Connor & Conner, 2007).

One participant, DK, talked about *perceived lack of control* as a cause for her restrictive eating. In her account, DK made it clear how she felt powerless in coping with the

"chaos" in her life at the time that she started restricting food and how her need to feel in control over different situations in her life, particularly family issues and starting university, led to her restrictive behaviour. In support of this finding, there is research evidence for the idea that need for control precedes restrictive eating patterns (e.g., Espindola & Blay, 2009; Patching & Lawler, 2009). DK's account also fits with Slade's (1982) theory in which he suggests that the need for control is central to the development and maintenance of AN.

Some of the participants (i.e., PA, EZ, DK) also understand their *DEBs as a consequence of growing up in a diet conscious environment*, which supports research demonstrating that family culture around food has an impact on individuals' relationship with food (Senra, Sanchez-Cao, Seoane & Leung, 2006). Previous studies that examined the eating behaviours of children who have parents with an ED history suggest that these children are more likely to have pathological eating behaviours (e.g., Reba-Harrelson, Von Holle, Hamer, Torgerson, Reichborn-Kjennerud, & Bulik, 2010). This literature is in line with the account of one participant (DK) who described her mother as being very anxious about her weight and also mentioned that she may have experienced some issues with food. Moreover, emotional abuse during childhood, including comments about physical appearance and weight, have been associated with negative view of the self in adulthood (Dunkley, Masheb, & Grilo, 2010) that in turn predicts binge-eating (Moulton, Newman, Power, Swanson, & Day, 2015; Smyth, Heron, Wonderlich, Crosby, & Thompson, 2008). Such findings resonate with the accounts of some of the participants in this research (PA and EZ) that talked about experiencing judgment and comments from their families in regard to the food they ate, their weight and physical appearance and how these experiences may have contributed to their current DEBs.

In addition to talking about experiencing emotional abuse from family members about their physical appearance and food choices during childhood, these participants and three others (TP, PG, DK) also talked about their *histories of CPV* and the enduring influences of

CPV on their lives now. Based on participants' accounts, current DEBs seemed to stem from an *unwanted sense of self* and *body dissatisfaction* that resulted from experiencing CPV, indicating that participants understand their DEBs as a result of the CPV experiences. The former was apparent in PA, EZ and PG's cases. For example, PA's conceptualisation of himself as "loser and fat" and EZ's explicit description of not liking herself as a trigger for her restrictive eating. This finding fits with the extant literature on the relationship between the experience of CPV and identity (e.g., Hoof, Raaijmakers, van Beek, Hale, & Aleva, 2008). According to Ylvisaker (2006), identity, along with an individual's self-worth, self-esteem, and self-image comprise the *sense of self* of an individual. Sense of self is defined as the way an individual thinks about his or her own characteristics that define them. These can include personal traits, hobbies, abilities, affiliations and beliefs (Ylvisaker, 2006). Moreover, an individual's sense of self is shaped based on their environment and immediate surroundings, including their interactions with others. This is consistent with the accounts of the participants in the present study that described how negative interactions with others and their experiences of CPV has affected their *sense of self* in a negative way, that in turn made them more vulnerable to DEBs.

The construct of *body dissatisfaction* under the *DEBs as a consequence of CPV experiences* subordinate theme was evident in EZ and PG's cases, in which both expressed body dissatisfaction as a result of frequent engagement in weight/appearance comparisons. The literature suggests that body dissatisfaction is among the strongest predictors for DEBs in women (Polivy & Herman, 2002) and that it can contribute to negative affect, especially in cultures where physical appearance is highly valued (i.e., Western culture) (e.g., Stice, 2001). Negative affect, in turn, is thought to increase DEBs (e.g., Fassino Leombruni, Piero, Abbate-Daga, & Rovera, 2003; Hudson, Hiripi, Pope, & Kessier, 2007; Torres & Nowson, 2007; Zeeck, Stelzer, Linster, Joos, & Hartmann, 2011). This is in line with participants' accounts of

the present study that were discussed under the *negative affect* subordinate theme above. Thus, the evidence cited here provides additional validation of participants' reports about their understanding of their DEBs as a response to negative affect and suggests that body dissatisfaction that stems from CPV experiences can contribute not only to DEBs directly but also indirectly through negative affect.

In addition, participants' understanding of their *DEBs as outcomes of CPV experiences* suggest support for theories arguing that negative experiences during childhood, including traumatic experience, increase individuals' risk for psychopathology in adulthood (e.g., Jeronimus, Ormel, Aleman, Penninx & Riese 2013; Macmillan, 2001) and for research suggesting a relationship between CPV experiences and the development of DEBs in later years (Engstrom & Norring, 2002; Striegel-Moore et al., 2002; Frank & Acle, 2014).

Furthermore, this finding is also in line with other qualitative studies that identified problems with peers/bullying as a common theme when examining participants' understanding of how their disordered eating emerged (e.g., Nilsson, Abrahamsson, Torbiornsson & Hagglof, 2007). Overall, the current findings suggest that CPV experiences may be a crucial factor that contributes to the development of body dissatisfaction and an unwanted sense of self than can, in turn, lead to DEBs later in life.

Theme Two: Functions and Maintaining Mechanisms of DEBs

The second theme, functions and maintaining mechanisms of DEBs, was supported by nine subordinate themes: 1) DEBs as an emotion regulation strategy, 2) DEBs experienced as enjoyable, 3) DEBs provide sense of identity, 4) Restriction provides sense of control, 5) Restriction provides sense of self-confidence, 6) External positive comments about appearance and weight, 7) Restriction as a way to elicit concern from significant others, 8) Sense of being powerless to stop DEBs, 9) Distorted beliefs.

The key finding of the subordinate theme *DEBs as an emotion regulation strategy* is that participants who binge understand their binge-eating behaviour as a coping response for negative emotions, which is what helps maintain their binge-eating. In line with the literature, all participants seem to experience emotion regulation difficulties to an extent (e.g., Cooper, O'Shea, Atkinson, & Wade, 2014; Eichen, Chen, Schmitz, Aslt, & McCloskey, 2016; Wollenberg, Shriver, & Gates, 2015). This was more evident in individuals who binge. While many different coping strategies for dealing with negative affect were discussed by participants, the most frequently mentioned from all participants who binge was *distraction*. This finding offers support for the Affect Regulation Model (Hawkins & Clement, 1984) and other theoretical models of EDs (e.g., Heatherton & Baumeister, 1991; Polivy & Herman, 1993) that emphasise the functional role of binge-eating as a coping strategy that helps regulate negative affect by providing distraction and short-term relief from the negative stimuli.

The present findings also suggest that DEBs are experienced as *enjoyable*. In particular, the enjoyable experience that participants identified in the present study was the positive change in their mood. Even in RI's narrative, where she doesn't explicitly describe binge-eating as something that she enjoys, it is evident that she experiences enjoyment during a binge-episode. The idea that the positive change in mood that results from binge-eating is what participants find enjoyable supports the literature on emotion regulation and DEBs (Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman, 1993). This change in negative affect during a binge episode has been suggested to be a crucial factor in explaining why binge-eating is maintained. As discussed above, researchers have posited that binge-eating shifts attention away from negative stimuli towards eating, reducing emotional distress and thus reinforcing binge-eating behaviour (Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman, 1993). Based on these theories, the positive mood

change, described as an enjoyable experience from the participants, could be the result of the 'escaping', 'distraction' and 'avoidance' of negative emotions achieved through binge-eating during a binge episode.

Interestingly, in PG's case, the positive mood change that was associated with dietary restriction seems to be more long-lasting, compared to the participants who binge (i.e., PA, EZ and RI) that described that the positive feeling of enjoyment was replaced by guilt after the binge episode ended. This finding is in line with literature indicating guilt as a commonly reported feeling following a binge episode (e.g., Goldschmidt et al., 2018). In their model for binge-eating, Polivy and Herman (1993) state that, despite the serious long-term negative effects that may accompany binge-eating, the immediate reduction of negative affect during a binge-episode perpetuates the binge-eating behaviour. This understanding of binge-eating as being negatively reinforced because of the short-term relief it provides may in part explain what was observed in participants' accounts of the present study: the reluctance to engage with the recognition that the positive effects of binge-eating are only short-term and that they are followed by negative emotions (i.e., guilt).

Another finding was that DEBs are experienced as providing a *sense of identity* to some of the participants. This finding is consistent with previous qualitative studies that identified identity among the emergent themes when examining individuals' experiences of living with AN (e.g., Espindola & Blay, 2009; Nordbo et al., 2006). The current research also involves participants with binge-eating behaviour and the identified theme *DEBs provide a sense of identity* was evident in PA's account in which binge-eating seemed to provide a sense of identity to him. This finding is also consistent with earlier theories that emphasise the lack of identity as contributing to the development of eating pathology (Bruch, 1981, 1982). The present findings, however, suggest that it is the fear of losing a part of the self that mainly drives the DEBs and thus the sense of identity subordinate theme in the present thesis. This

was more pronounced in DK's account where she explicitly describes that she is afraid of losing a part of who she is if she stops restricting.

In talking about their experiences with DEBs, some of the participants also talked about experiencing a *sense of control* and *self-confidence* through restriction. According to Slade (1982) the need for control that plays a pivotal role in the etiology and maintenance of AN, is manifested in food restriction that is maintained through the resulting feelings of success after successfully restricting food (i.e., positive reinforcement) and the avoidance of other fears related to food (i.e., negative reinforcement). This feeling of success that results from the sense of control achieved through food restriction is also related to the subordinate theme of *self-confidence*, again evident in individuals who mentioned restriction (i.e., EZ, PG, DK). Successful control of food intake gives rise to a sense of control that in turn increases the sense of self-confidence, making restriction highly rewarding and thus resistant to change (Slade, 1982). Based on this, the increased sense of self-confidence is also a factor that maintains restriction. The sense of control as an outcome of restriction and its' relationship to self-confidence was indeed expressed in participants' accounts. Restriction was understood by participants as providing a sense of control that they otherwise did not experience in their lives and by successfully controlling their food intake, participants described feeling more confident in controlling important things in their lives. For instance, in PG's case, restriction was described as giving her a sense of control that contributed to her sense of self-confidence and ability to focus and study, which at that time was important for her.

Related to the sense of self-confidence theme is also the subordinate theme *external positive comments about appearance and weight*. It seems that receiving positive feedback about their appearance and weight was a particularly powerful reinforcer for participants' DEBs that also contributed to an increased sense of self-confidence. DK's account, for example, suggests that the positive comments that she received from others were of high

importance to her when she started losing weight and she reports that a reason that she continues to restrict is that she is afraid of the negative comments that she might receive if she puts on weight. The positive comments that participants received from others about their appearance helped them improve their self-confidence, making it even harder to stop restricting. This finding fits with literature emphasising the reinforcing effects of external positive comments about physical appearance as a maintaining factor for restriction (e.g., Walsh, 2013).

Oldershaw, Startup, and Lavender (2019) suggested that any emotion expressed around eating by significant others may represent emotional engagement, which can act as a strong reinforcer for DEBs. This is evident in the account of one of the participants (PG) in the present study in which concern expressed from her parents when she started changing her diet and losing weight reinforced her restrictive behaviour. In this case, therefore, food restriction functioned as a way to elicit concern from significant others. The subordinate theme *restriction as a way to elicit concern from significant others* found in this study is also in line with literature suggesting that food provides means to communicate valued needs (i.e., emotional needs) to others (e.g., Serpell, Teasdale, Troop, & Treasure, 2004), highlighting the functional role of restrictive behaviour.

The subordinate theme *sense of being powerless to stop DEBs* was a particularly interesting theme that emerged from the narratives of all participants, except PG's. Participants made clear the extent to which they felt powerless in controlling their DEBs. In PA's account this sense of powerlessness was even more pronounced as he seemed to always expect failure due to his repeated failed attempts to control binge-eating from a young age.

Lastly, the findings of the present study suggest that DEBs could be perpetuated by certain *distorted beliefs*. In talking about their experiences of DEBs, participants frequently made several statements that implied distorted beliefs associated with food, weight and shape.

For example, in PG's narrative a common distorted belief was the belief that specific foods can cause immediate weight gain, which led to the avoidance of specific foods. The same distorted belief was also apparent in EZ's narrative which was also associated with restriction of food. This finding is in agreement with the cognitive theories of eating disorders (e.g., Fairburn, 1997; Fairburn, Cooper, & Cooper, 1986; Garner & Bemis, 1982) and more specifically the transdiagnostic cognitive-behavioural model for eating disorders (Fairburn, Cooper, & Shafran, 2003) that posit that cognitive distortion serve to maintain dysfunctional behaviour, such as disordered eating.

Limitations and future research

Certain limitations need to be acknowledged regarding the present phase of this thesis. For instance, the generalisability of the present findings is subject to certain limitations. The sample was limited to a non-clinical population with Greek-Cypriot nationality and were all university students. Although, the current findings may be valid for the experiences of DEBs for this particular group, caution should be taken when generalizing to the wider population of emerging adults with a history of CPV. It is possible that different themes would have emerged using a different sample. Therefore, further research could be done to investigate whether clinical population, individuals with different nationalities, as well as individuals of lower educational attainment assign similar meanings to their DEBs.

Similarly, it would also be useful for future research to implement IPA studies to examine how emerging adults who have experienced other forms of childhood interpersonal trauma experience DEBs.

Moreover, given the evidence of higher degree of eating pathology in individuals who choose not to participate in studies (Dingemans, Bruna, & van Furth, 2002), it's possible that emergent themes may have been different in the non-respondent group. Therefore, caution should be taken when interpreting the current findings.

Another important limitation regarding the present study is that all interviews were conducted online using ZOOM video conferencing. While research suggests no significant differences in the type of participants' responses when compared to face-to-face interviewing (e.g., Deakin & Wakefield, 2013; Wood & Griffith, 2007c), certain limitation need to be acknowledged with respect to this. For instance, due to the nature of video conferencing, the researcher might have missed opportunities to respond to body language and emotional cues from the participants that could have affected participants' responses and openness (Cater, 2011). Also, it can be argued that conducting the interviews online may have influenced rapport building between the researcher and the participants. However, there is evidence to suggest that participants in video conferencing interviews create rapport quicker compared to participants in face-to-face interviewing (e.g., Deakin & Wakefield, 2014; Tuttas, 2015). Moreover, some researchers suggest that exchanging emails with the participants before the video conferencing can contribute to rapport building (Deakin & Wakefield, 2013). In the present study, the researcher exchanged several emails with the participants to introduce herself and to arrange the interview date. In addition, before the beginning of the interview the researcher allowed some time to introduce herself in more detail, describe the aim of the interview, the confidentiality policy and gave participants the opportunity to ask any questions they wanted, things that contribute to rapport building as well (Kvale & Brinkmann, 2009). Accordingly, it is most likely that rapport building was not affected in the present thesis.

Furthermore, as mentioned in the methods section above, the interviews were conducted in Greek language. Although the translation of the interviews from Greek to English has been done carefully, some issues in regard to the vocabulary used might have been generated. However, the researcher that conducted both the interviews and the analyses is fluent in both English and Greek languages and this might have posed an advantage for the translation process.

Finally, there are certain points that need to be discussed in regard to the methodology used to analyse the present data. First, due to the idiographic nature of IPA analysis, a rather small sample size is needed (Smith, Flowers, & Larkin, 2009). Although the small sample size of the current study (i.e., six participants) might be a further limitation, Smith and colleagues (2009) suggested that a smaller number of participants allows for a more in-depth analysis of the phenomenon under study that would have not been possible with larger sample sizes (Smith Flowers, & Larkin, 2009). In regard to the generalizability of the findings, Willig (2008) argued against small sample sizes and suggested that any claims made from the findings of a study should be restricted to the group of participants studied. Nonetheless, Willig (2008) also stated that, although we can't be sure of the number of individuals that share the same experience with the participants, findings from qualitative studies using small sample sizes indicate that a particular experience exists, and this can encourage further research. Hence, whilst the findings of the present thesis provide information into how emerging adults with a history of CPV experience DEBs, caution should be taken when generalising them to the wider population of emerging adults with a history of CPV.

Second, it is acknowledged that the findings of the present study are a result from an analysis that is by its very nature subjective to both the researcher's and participants' interpretations (i.e., double hermeneutics), which may give rise to questions in regard to the credibility and significance of the findings. However, in the present study, an audit trail was developed by the researcher, which according to Smith and colleagues (2009), contributes to the credibility and trustworthiness of the results.

Contributions and Implications

The present study was designed to explore the experiences of DEBs in emerging adults with a history of CPV. The findings indicate that for the participants who were interviewed, DEBs were experienced and understood in terms of how they developed and triggered (*causes*

and triggers for current DEBs), and in terms of how they persist (*functions and maintaining mechanisms of DEBs*). Despite the limitations mentioned above this qualitative study provides new and potentially useful information in an area that has not been researched much in the past, specifically how emerging adults who also have a history of CPV interpret their experiences with DEBs.

The findings have highlighted that DEBs represent psychologically purposeful behaviours in this population. Specifically, that DEBs hold different meanings that could contribute to the maintenance of DEBs. Along with emotion regulation functions, DEBs seem to provide other functions such as a sense of identity, control, self-confidence and pleasure in emerging adults who have experienced CPV. This explains why many participants in the present study seemed to be resistant to cease their disordered eating patterns despite recognizing their negative effects. It could therefore be suggested that interventions that help build effective emotion regulation skills, self-confidence and establish an identity that is not attached to the DEBs may be essential in treatments that target DEBs in emerging adults with CPV history.

This study also provides support for the theoretical models of eating pathology that emphasise the role of eating disorder behaviours in regulating negative affect (e.g., Bruch, 1973; Fairburn, Shafran, & Cooper, 1999; Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman, 1985). In addition, the results of the present thesis suggest that models for eating pathology could benefit from the inclusion of socio-cultural stressors outside of the family, such as CPV, since participants' accounts suggest that DEBs were among the outcomes of peer victimization experienced in childhood. These results therefore highlight the value of investigating further such socio-cultural stressors as contributing to the development of eating pathology.

Given this finding that underlines the enduring impact of CPV experiences in later years it is suggested that enquiring about CPV experiences should be an integral part of interventions that target DEBs in emerging adults. In addition, the findings emphasise body dissatisfaction and unwanted sense of self as outcomes of the CPV experiences that contribute to the development of DEBs. Although the literature on body dissatisfaction and DEBs is well-established (e.g., Polivy & Herman, 2002), literature on the sense of self and how it relates to CPV and DEBs is very limited. The current field could therefore benefit from investigating the 'sense of self' in these individuals and its' relation to CPV and DEBs.

Finally, the findings of the present study have indicated the need for more qualitative research into the phenomenology of DEBs and in particular into the experience of DEBs in emerging adults who have a history of CPV. The insights from this study make significant contributions to the field of eating pathology by enhancing our understanding of what contributes to the vulnerability of DEBs in emerging adults with CPV history and creating new directions for future research.

General Conclusion

The present thesis used an exploratory mixed-method design to explore the relationship between CPV and DEBs in emerging adults. Quantitative measures of DEBs, retrospective bullying victimization, identity development and emotion regulation difficulties combined with qualitative semi-structured interviews on a subset of participants from the quantitative phase provided several sources of data to help understand the complex relationship between CPV and the development of DEBs in emerging adulthood.

Drawing from the results from both quantitative and qualitative phases, harmful CPV experiences appear to contribute to the development of DEBs in emerging adulthood. Both restrictive and binge-eating behaviours in emerging adults were associated with retrospective reports of CPV experiences and the qualitative results indicated that all participants, except

one, understood restrictive and binge-eating as a consequence of CPV experiences. This is an important finding as it highlights the enduring influence of CPV experiences on emerging adults' well-being and suggests that exposure to traumatic events, such as peer victimization in childhood can increase emerging adults' vulnerability to DEBs.

The qualitative findings of the present thesis provided further insights into this relationship. In particular, two themes emerged in participants' accounts when they discussed the enduring influence of CPV experiences on their current DEBs: a) body dissatisfaction and b) living with an unwanted sense of self. The theme, living with an unwanted sense of self, that was mentioned repeatedly among participants who binge, was an especially important finding as it is not regularly discussed in studies of peer victimization and eating pathology.

In addition, the quantitative data indicated that pathological identity development was positively related to binge-eating, supporting the indirect relationship of CPV to binge-eating through pathological identity development. However, the indirect relationship between CPV and restrictive eating through pathological identity development was not supported. This was an interesting finding given that restrictive eating was explicitly described as providing a sense of identity to participants in the qualitative phase. This rather contradictory result between the quantitative and qualitative findings may be due to the measure used to assess identity pathology in the quantitative phase, since the qualitative findings highlight that it is the fear of losing a part of the self that mainly drives the restrictive behaviour, rather than the lack of a clear sense of identity. Therefore, it may be that for restrictive eating in these population, the fear of losing a part of one's identity is of greater importance rather than the actual pathological identity development.

The qualitative results also suggest that peer victimized individuals with DEBs have difficulties in coping with intense negative emotions and as a result often use DEBs as an emotion regulation strategy. In their narratives, participants specifically described

experiencing binge-eating as a distraction that helped them cope with negative emotions. While this finding is compatible with many theoretical accounts on eating pathology and emotion regulations (e.g., Bruch, 1973; Fairburn, Shafran, & Cooper, 1999; Hawkins & Clement, 1984; Heatherton & Baumeister, 1991; Polivy & Herman, 1985), the quantitative results of the present thesis failed to support the moderating role of emotion regulation difficulties in the relationship between CPV and emerging adults' DEBs. However, this does not mean that the accounts of participants from the qualitative phase are invalid. As mentioned in the discussion section for the quantitative results, there may be other factors that are more relevant in emerging adults with a history of CPV that moderate this relationship, including social support. According to the qualitative data of the present thesis, social support could indeed be a possible factor moderating this relationship as it was found that DEBs, restriction in particular, was experienced as a means that helped elicit concern from significant others. Such concern elicited from others as a result of restrictive eating could in turn be interpreted by individuals as a form of support. Further research however is needed to examine this.

Several other interesting themes emerged from the qualitative phase complementing the results from the quantitative phase, including: DEBs experienced as a response to negative affect, DEBs experienced as a response to perceived lack of control, DEBs experienced as a consequence of growing up in a diet conscious environment, DEBs experienced as enjoyable, restriction provides sense of control, restriction provides sense of self-confidence, sense of being powerless to stop DEBs, and distorted beliefs . The key idea from the qualitative findings is that the participants interpret their experiences with DEBs in terms of how they developed and are triggered, and in terms of how they persist. Most importantly they seem to understand their DEBs as an outcome of their CPV experiences, providing additional support for quantitative results.

In summary, this research has made significant contributions to the field of CPV, eating pathology and emerging adulthood and has provided new and potentially useful information in an area that has not been researched much in the past, specifically how emerging adults who also have a history of CPV experience DEBs. The combination of quantitative and qualitative results has led to a richer, more comprehensive understanding of DEBs in emerging adults with a history of CPV than would not have been achieved from using either method alone.

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APPENDIX A

Consent form from Survey Monkey for the quantitative phase

Α. Σκοπός της έρευνας

Η παρούσα έρευνα επιδιώκει να διερευνήσει τους παράγοντες που συμβάλλουν στην ανάπτυξη τριών διαφορετικών τύπων διαταραγμένων διατροφικών συμπεριφορών στην αναδυόμενη ενηλικίωση (18-25 ετών).

Οι στόχοι της παρούσας έρευνας θα επιτευχθούν μέσα από δυο ξεχωριστές φάσεις.

Αρχικά, κατά την πρώτη φάση της έρευνας θα σας ζητηθεί να συμπληρώσετε ερωτηματολόγια αυτοαναφοράς που αφορούν δημογραφικά χαρακτηριστικά, τις διατροφικές σας συμπεριφορές, ταυτότητα, τις ικανότητες ρύθμισης των συναισθημάτων σας και την εμπειρία σας σχετικά με σχολικό εκφοβισμό στην παιδική ηλικία.

Για την 2η φάση της έρευνας έχει σχεδιαστεί ποιοτική έρευνα με ημιδομημένες συνεντεύξεις. Με βάση τις απαντήσεις σας στα ερωτηματολόγια της 1ης φάσης θα κρίνουμε εάν θα σας καλέσουμε να λάβετε μέρος στην 2η φάση της έρευνας. Δεν θα ζητηθεί από όλους τους συμμετέχοντες να συμμετάσχουν στην 2η φάση.

Β. Αναμενόμενο όφελος για τους συμμετέχοντες

Δεν θα υπάρξουν προσωπικά οφέλη από την συμμετοχή σας σε αυτή την έρευνα. Ωστόσο, η συμμετοχή σας θα προσφέρει πολύτιμες γνώσεις που μπορούν να συμβάλλουν στην ανάπτυξη στοχευμένων παρεμβάσεων για την μείωση του κινδύνου ανάπτυξης διαταραγμένων διατροφικών συμπεριφορών, καθώς και διατροφικών διαταραχών στους νέους.

Γ. Συμμετοχή στην έρευνα

Η συμμετοχή σας στην παρούσα έρευνα είναι εθελοντική. Ο κάθε συμμετέχοντας έχει το δικαίωμα να άρει την συμμετοχή του στην έρευνα ανά πάσα στιγμή το θελήσει χωρίς κάποια συνέπεια (κατά την διάρκεια της συμπλήρωσης των ερωτηματολογίων ή και της συνέντευξης, καθώς και μετά το τέλος της συμπλήρωσης των ερωτηματολογίων ή και της συνέντευξης). Επίσης, έχετε το δικαίωμα να αρνηθείτε να απαντήσετε σε οποιεσδήποτε ερωτήσεις δεν επιθυμείτε να απαντήσετε και να παραμείνετε στην έρευνα

Δ. Πρόσβαση και διαφύλαξη δεδομένων

Δεν υπάρχουν προβλέψιμοι κίνδυνοι που προκύπτουν από τη συμμετοχή σας στην παρούσα έρευνα. Ωστόσο, υπάρχει ενδεχόμενο να αισθανθείτε άσχημα ή/και να νιώσετε ότι φορτίζεστε ψυχολογικά διαβάζοντας (1η φάση) για τα θέματα που αφορούν την παρούσα έρευνα λόγω του ευαίσθητου της περιεχομένου.

Ασφαλώς θα έχετε το δικαίωμα να αποχωρήσετε από την έρευνα οποιανδήποτε στιγμή το θελήσετε επικοινωνώντας με τον επιστημονικό υπεύθυνο ή την ερευνήτρια. Θα έχετε επίσης το δικαίωμα να ζητήσετε να παραληφθούν οι απαντήσεις σας αφότου συμπληρώσετε τα ερωτηματολόγια.

Στα πλαίσια της έρευνας θα συλλεχθούν μόνο οι πληροφορίες οι οποίες είναι απαραίτητες για την διεξαγωγή της έρευνας. Αυτές συμπεριλαμβάνουν: δημογραφικά στοιχεία (φύλο, ημερομηνία γέννησης, βάρος και ύψος στην παρούσα φάση, εθνικότητα, ανώτερο ακαδημαϊκό επίπεδο, επάγγελμα), στοιχεία επικοινωνίας (ηλεκτρονική διεύθυνση), πληροφορίες για την εμπειρία σας σχετικά με τον εκφοβισμό στην παιδική ηλικία, για τις παρούσες διατροφικές σας συμπεριφορές αλλά και για θέματα που αφορούν την ταυτότητα και την ικανότητα ρύθμισης των συναισθημάτων σας.

Τα δεδομένα που θα συλλεχθούν στην παρούσα έρευνα θα διαφυλάσσονται σε USBs τα οποία θα έχουν κωδικό πρόσβασης. Θα βρίσκονται σε κλειδωμένους χώρους, όπου μόνο η ερευνήτρια (Μαρία Μάρκου) θα έχει πρόσβαση. Όσον αφορά το ακουστικό αρχείο του κάθε συμμετέχοντα που θα προκύψει από την 2η φάση της έρευνας, θα φυλαχθεί σε ντουλάπι ασφαλείας (με κωδικό πρόσβασης) στο γραφείο της ερευνήτριας όπου μόνο αυτή θα έχει πρόσβαση. Ο επιστημονικός υπεύθυνος (Δρ. Παναγιώτης Σταυρινίδης) θα έχει πρόσβαση μόνο στα ανώνυμα δεδομένα.

Τα ανώνυμα δεδομένα θα χρησιμοποιηθούν στη διάχυση των ευρημάτων της έρευνας σε διεθνή επιστημονικά περιοδικά και θα καταστραφούν αφού ολοκληρωθεί η έρευνα.

Ε. Πληροφορίες για υπηρεσίες ψυχολογικής στήριξης

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APPENDIX B

Questionnaires completed by participants in order of appearance in the survey

ΜΕΡΟΣ Α

Οι πιο κάτω προτάσεις ασχολούνται με τις συνήθειες σας, τα συναισθήματα και γενικά την όλη συμπεριφορά σας σχετικά με τα τρόφιμα και τη διατροφή σας.

Μέρος 1: Παρακαλώ διαβάστε την κάθε πρόταση προσεκτικά και απαντήστε με βάση το πόσο συχνά συμβαίνουν τα ακόλουθα (π.χ. ΠΑΝΤΑ, ΣΥΝΗΘΩΣ, ΣΥΧΝΑ, ΜΕΡΙΚΕΣ ΦΟΡΕΣ, ΣΠΑΝΙΑ ή ΠΟΤΕ). Επιλέξτε το κουτί που εκφράζει καλύτερα την περίπτωσή σας.

* 8. Τρώω όταν είμαι αναστατωμένος/η για κάτι

- ◯ Πάντα
- ◯ Συνήθως
- ◯ Συχνά
- ◯ Μερικές φορές
- ◯ Σπάνια
- ◯ Ποτέ

* 9. Γεμίζω τον εαυτό μου με φαγητό

- ◯ Πάντα
- ◯ Συνήθως
- ◯ Συχνά
- ◯ Μερικές φορές
- ◯ Σπάνια
- ◯ Ποτέ

* 10. Έχω πέσει σε ανεξέλεγκτη κατανάλωση φαγητών και νόμισα πως δεν θα μπορούσα να σταματήσω

- ◯ Πάντα
- ◯ Συνήθως
- ◯ Συχνά
- ◯ Μερικές φορές
- ◯ Σπάνια
- ◯ Ποτέ

* 11. Σκέφτομαι να καταφύγω στην υπερφαγία

- ◯ Πάντα
- ◯ Συνήθως
- ◯ Συχνά
- ◯ Μερικές φορές
- ◯ Σπάνια
- ◯ Ποτέ

* 12. Τρώω λίγο μπροστά στους άλλους αλλά τρώω πολύ όταν φύγουν

- ◯ Πάντα
- ◯ Συνήθως
- ◯ Συχνά
- ◯ Μερικές φορές
- ◯ Σπάνια
- ◯ Ποτέ

* 13. Τρώω ή πίνω κρυφά

- ◯ Πάντα
- ◯ Μερικές φορές
- ◯ Συνήθως
- ◯ Σπάνια
- ◯ Συχνά
- ◯ Ποτέ

* 14. Όταν είμαι αναστατωμένος/η, ανησυχώ μήπως αρχίσω να τρώω

- ◯ Πάντα
- ◯ Μερικές φορές
- ◯ Συνήθως
- ◯ Σπάνια
- ◯ Συχνά
- ◯ Ποτέ

ΜΕΡΟΣ Β

* 21. Έχετε προσπαθήσει ηθελημένα να περιορίσετε την ποσότητα του φαγητού που τρώτε, ώστε να αλλάξετε το σώμα σας ή το βάρος σας (είτε το καταφέρατε είτε όχι);

- Καμία μέρα
- 1-5 μέρες
- 6-12 μέρες
- 13-15 μέρες
- 16-22 μέρες
- 23-27 μέρες
- Κάθε μέρα

* 22. Έχετε περάσει μακρές περιόδους (8 ή περισσότερες ώρες εκτός του ύπνου) χωρίς να έχετε φάει τίποτα, ώστε να αλλάξετε το σώμα σας ή το βάρος σας;

- Καμία μέρα
- 1-5 μέρες
- 6-12 μέρες
- 13-15 μέρες
- 16-22 μέρες
- 23-27 μέρες
- Κάθε μέρα

* 23. Έχετε προσπαθήσει να αποκλείσετε από τη διατροφή σας φαγητά τα οποία σας αρέσουν ώστε να αλλάξετε το σώμα σας ή το βάρος σας (είτε το καταφέρατε είτε όχι);

- Καμία μέρα
- 1-5 μέρες
- 6-12 μέρες
- 13-15 μέρες
- 16-22 μέρες
- 23-27 μέρες
- Κάθε μέρα

* 24. Έχετε προσπαθήσει να ακολουθήσετε ξεκάθαρους κανόνες σχετικά με τη διατροφή σας (π.χ. περιορισμό θερμίδων) ώστε να αλλάξετε το σώμα σας ή το βάρος σας (είτε το καταφέρατε είτε όχι);

- Καμία μέρα
- 1-5 μέρες
- 6-12 μέρες
- 13-15 μέρες
- 16-22 μέρες
- 23-27 μέρες
- Κάθε μέρα

* 25. Είχατε ξεκάθαρη επιθυμία να έχετε άδειο στομάχι με σκοπό να αλλάξετε το σώμα σας ή το βάρος σας;

- Καμία μέρα
- 1-5 μέρες
- 6-12 μέρες
- 13-15 μέρες
- 16-22 μέρες
- 23-27 μέρες
- Κάθε μέρα

ΜΕΡΟΣ Γ

Μέρος 1: Παρακαλώ διαβάστε τις πιο κάτω προτάσεις προσεκτικά και απαντήστε με βάση το πόσο συχνά συμβαίνουν τα ακόλουθα. Επιλέξτε το κουτί που εκφράζει καλύτερα την περίπτωσή σας.

* 26. Αναγνωρίζω ξεκάθαρα το τι νιώθω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 27. Δίνω σημασία για το τι νιώθω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 28. Βιώνω τα συναισθήματά μου ως αφόρητα και έξω από τον έλεγχό μου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 29. Δεν έχω ιδέα για το πως νιώθω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 30. Δυσκολεύομαι να κατανοήσω αυτό που νιώθω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 31. Είμαι προσεκτικός/η αναφορικά με τα συναισθήματά μου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 32. Ξέρω ακριβώς τι νιώθω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 33. Προσέχω τι νιώθω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 34. Είμαι μπερδεμένος/η για το πως νιώθω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 35. Όταν είμαι αναστατωμένος/η, αναγνωρίζω τα συναισθήματά μου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 36. Όταν είμαι αναστατωμένος/η, θυμώνω με τον εαυτό μου που νιώθω έτσι

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 37. Όταν είμαι αναστατωμένος/η, είμαι αμήχανος/η που νιώθω έτσι

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 38. Όταν είμαι αναστατωμένος/η, δυσκολεύομαι να τελειώσω αυτό που κάνω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 39. Όταν είμαι αναστατωμένος/η, είμαι εκτός ελέγχου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 40. Όταν είμαι αναστατωμένος/η, πιστεύω ότι αυτό θα κρατήσει για πολύ

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 41. Όταν είμαι αναστατωμένος/η, πιστεύω ότι θα σταματήσω να νιώθω θλιμμένος/η

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 42. Όταν είμαι αναστατωμένος/η, πιστεύω ότι τα συναισθήματά μου ισχύουν και είναι σημαντικά

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 43. Όταν είμαι αναστατωμένος/η, δυσκολεύομαι να εστιαστώ σε κάτι

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 44. Όταν είμαι αναστατωμένος/η, νιώθω ότι είμαι εκτός ελέγχου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 45. Όταν είμαι αναστατωμένος/η, μπορώ να τελειώσω κάτι που κάνω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 46. Όταν είμαι αναστατωμένος/η, νιώθω ντροπή που νιώθω με αυτό τον τρόπο

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 47. Όταν είμαι αναστατωμένος/η, ξέρω ότι μπορώ να βρω τον τρόπο που τελικά θα νιώσω καλύτερα

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 48. Όταν είμαι αναστατωμένος/η, νιώθω ότι είμαι αδύναμος/η

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 49. Όταν είμαι αναστατωμένος/η, νιώθω ότι μπορώ να ελέγχω τη συμπεριφορά μου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 50. Όταν είμαι αναστατωμένος/η, νιώθω ενοχές που νιώθω με αυτό τον τρόπο

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 51. Όταν είμαι αναστατωμένος/η, δυσκολεύομαι να συγκεντρωθώ

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 52. Όταν είμαι αναστατωμένος/η, δυσκολεύομαι να ελέγξω τη συμπεριφορά μου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 53. Όταν είμαι αναστατωμένος/η, πιστεύω ότι δεν υπάρχει τίποτα που μπορώ να κάνω για να νιώσω καλύτερα

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 54. Όταν είμαι αναστατωμένος/η, γίνομαι ευερέθιστος/η με τον εαυτό μου που νιώθω με αυτό τον τρόπο

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 55. Όταν είμαι αναστατωμένος/η, αρχίζω να νιώθω πολύ άσχημα για τον εαυτό μου

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 56. Όταν είμαι αναστατωμένος/η, πιστεύω ότι αν μείνω κολλημένος/η σ'αυτό είναι το μόνο που μπορώ να κάνω

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 57. Όταν είμαι αναστατωμένος/η, χάνω τον έλεγχο για όλες μου τις συμπεριφορές

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 58. Όταν είμαι αναστατωμένος/η, δυσκολεύομαι να σκεφτώ κάτι άλλο

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 59. Όταν είμαι αναστατωμένος/η, παίρνω χρόνο για να καταλάβω το τι νιώθω πραγματικά

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 60. Όταν είμαι αναστατωμένος/η, χρειάζομαι αρκετό χρόνο για να νιώσω καλύτερα

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

* 61. Όταν είμαι αναστατωμένος/η, τα συναισθήματά μου είναι αφόρητα

- Σχεδόν ποτέ (0-10%)
- Μερικές φορές (11-35%)
- Περίπου το μισό του χρόνου (36-65%)
- Το περισσότερο του χρόνου (66-90%)
- Πάντα (91-100%)

ΜΕΡΟΣ Δ

Πιο κάτω ακολουθούν προτάσεις που περιγράφουν τη στάση, τη γνώμη, τα ενδιαφέροντα και άλλα προσωπικά συναισθήματα νέων ανθρώπων, όπως εσάς.

Οι προτάσεις αυτές μπορεί να ισχύουν για σας σε μεγαλύτερο ή μικρότερο βαθμό. Παρακαλώ επιλέξετε την απάντηση που περιγράφη καλύτερα την περίπτωσή σας.

* 82. Έχω χόμπι και ενδιαφέροντα που με εκφράζουν

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 83. Νιώθω άνετα στη κοινωνία που ζω. Εκεί ανήκω.

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 84. Συχνά δεν μπορώ να προσδιορίσω πως νιώθω τη κάθε στιγμή

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 85. Νιώθω σαν να έχω πολλά διαφορετικά πρόσωπα τα οποία δεν ταιριάζουν πολύ μεταξύ τους

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 86. Μου είναι δύσκολο να βρίσκομαι ταυτόχρονα με 2 ή 3 φίλους. Αυτό πάντα μου δημιουργεί πρόβλημα με κάποιο τρόπο

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 87. Δεν θυμάμαι πως ένιωθα και σκεφτόμουν σαν παιδί. Τώρα νιώθω διαφορετικό άτομο

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 88. Συχνά διαφωνώ με τους φίλους μου. Για σύντομα χρονικά διαστήματα σταματώ να τους κάνω παρέα και μετά ξαναγινόμαστε φίλοι

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 89. Όταν κοιτάζομαι στο καθρέπτη, συχνά ξαφνιάζομαι και δεν μου αρέσει που έχω αλλάξει

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 90. Δεν είμαι σίγουρος ότι οι φίλοι μου με συμπαθούν πραγματικά

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 91. Όταν οι άλλοι με βλέπουν σε καινούργιες καταστάσεις, εκπλήσσονται με αυτό που είμαι

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 92. Κάποιες φορές νιώθω σαν να «χάνομαι» σε μια φιλική σχέση, γιατί δεν εκφράζω τις ανάγκες μου

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 93. Κάποιες φορές νιώθω ψεύτικος/η, γιατί ο εξωτερικός μου εαυτός δεν ταιριάζει με τον εσωτερικό μου (εαυτό)

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 94. Μπορώ να εμπιστευτώ το ένστικτό μου. Συνήθως με οδηγεί στη σωστή κατεύθυνση

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 95. Νιώθω σαν να μην ανήκω πραγματικά κάπου

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 96. Φοβάμαι ότι πολλοί από τους φίλους μου θα με άφηναν μόνο/η μου, όταν θα τους χρειαζόμουν

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 97. Κάποιες φορές, νιώθω ότι τα ενδιαφέρονται μου δεν είναι πραγματικά «δικά μου», αλλά ότι τα υιοθέτησα από άλλους

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 98. Όταν οι φίλοι μου διαφωνούν με τη γνώμη και τις ιδέες μου, νιώθω ταπεινωμένος/η

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 99. Κάνω φιλίες με ανθρώπους που δεν συμπαθώ, γιατί δεν μπορώ να πω όχι

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 100. Συχνά δεν είμαι σίγουρος/η κατά πόσο κάνω το σωστό για τον εαυτό μου

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 101. Κάποιες φορές νιώθω έντονα συναισθήματα χωρίς να ξέρω το γιατί

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 102. Συχνά, αντιλαμβάνομαι τη συμπεριφορά μου πολύ διαφορετικά απ' ό,τι την αντιλαμβάνονται οι φίλοι μου

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 103. Νιώθω "άδειος/α"

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 104. Μπορώ να φανταστώ πως μπορεί να είμαι σε μερικά χρόνια

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 105. Μου είναι δύσκολο να μη νιώθω ούτε ανώτερος/η ούτε κατώτερος/η σε σχέση με τους άλλους

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 106. Είμαι μπερδεμένος/η σχετικά με το τι είδους άτομο είμαι πραγματικά

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 107. Δεν μπορώ να παρακολουθώ το τι κάνω ή πότε κάνω κάτι και γιατί το κάνω

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 108. Εάν με επικρίνουν οι άλλοι ή με δουν να αποτυγχάνω, νιώθω πραγματικά άχρηστος/η και "κατεστραμμένος/η"

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 109. Νιώθω άνετα με το σώμα μου

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 110. Συνήθως δεν έχω "σταθερές σχέσεις" (μία είμαστε μαζί και μία χωρίζουμε)

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 111. Φοβάμαι ότι κάποια στιγμή οι φίλοι μου θα πάψουν να με συμπαθούν και θα με απομονώσουν

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 112. Συχνά νιώθω σαν να μπορούσα να είμαι "πολλά άτομα" μαζί και όχι μόνο ένα, και αυτό επειδή έχω τόσες πολλές διαφορετικές απόψεις και διαθέσεις

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 113. Μου είναι δύσκολο να είμαι μόνος/η μου

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 114. Νιώθω εντελώς μπερδεμένος/η όταν η διάθεσή μου αλλάζει ξαφνικά

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 115. Συχνά παθαίνω μπλακ άουτ (δεν μπορώ να απαντήσω), όταν αναρωτιέμαι γιατί κάνω ορισμένα πράγματα

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 116. Χρειάζομαι ενθάρρυνση προκειμένου να μη παραιτηθώ από αυτό που κάνω

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 117. Οι φιλίες μου συνήθως διαρκούν μόνο μερικούς μήνες

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 118. Νιώθω ότι εσωτερικά είμαι δυνατός/η ανεξάρτητα από το τι συμβαίνει έξω

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 119. Συχνά οι άλλοι μου λένε πως αντιφάσκω με τον εαυτό μου, αλλά εγώ δεν το νομίζω

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

* 120. Πιστεύω ότι θα βρω τη θέση μου στο κόσμο

- Ισχύει για μένα ισχυρότερα
- Ισχύει κάπως
- Ούτε ισχύει ούτε δεν ισχύει
- Δεν ισχύει εντελώς
- Δεν ισχύει καθόλου

ΜΕΡΟΣ Ε

Οι πιο κάτω ερωτήσεις αφορούν τον σχολικό εκφοβισμό.

Ο σχολικός εκφοβισμός αναφέρεται στην χρήση βίας, συχνά επαναλαμβανόμενα, μεταξύ συνομηλίκων με στόχο την πρόκληση πόνου ή αναστάτωσης. Αποτελεί μια σκόπιμα κακόβουλη συμπεριφορά κα μπορεί να εμφανιστεί σε διάφορες μορφές.

Για παράδειγμα, μπορεί να είναι **1) λεκτικός εκφοβισμός** (κοροϊδία, διακρίσεις, ντροπιαστικά σχόλια), **2) κοινωνικός εκφοβισμός** (διάδοση φημών, καταστροφή προσωπικών αντικειμένων, απομόνωση από την ομάδα), **3) σωματικός εκφοβισμός** (χτυπήματα, σπρωξίματα, κλωτσιές), **4) ηλεκτρονικός εκφοβισμός** (εκβιασμός μέσω Διαδικτύου και ηλεκτρονικού ταχυδρομείου, μέσω μηνυμάτων στο κινητό τηλέφωνο).

* 121. Παρακαλώ θυμηθείτε τη ζωή σας στο σχολείο. Πιθανώς να έχετε δει κάποιο περιστατικό εκφοβισμού στο σχολείο και ίσως, με κάποιο τρόπο, να έχετε εμπλακεί.

Με βάση τον πιο πάνω ορισμό του εκφοβισμού επιλέξετε την απάντηση που περιγράφει καλύτερα τις εμπειρίες σας στο σχολείο.

- ◯ Δεν έχω εμπλακεί σε σχολικό εκφοβισμό, ούτε αντιλήφθηκα ποτέ να συμβαίνει κάποιο περιστατικό
- ◯ Μερικές φορές μου ασκήθηκε εκφοβισμός απο συμμαθητές μου
- ◯ Δεν είχα καμία εμπλοκή, ωστόσο είδα κάποιες φορές να συμβαίνει
- ◯ Κατά καιρούς υπήρξα και θύτης και θύμα (bully/victim, και έχ κάνει και μου έχουν κάνει)
- ◯ Μερικές φορές συμμετείχα στον εκφοβισμό άλλων

Μέρος 1: Αυτό το μέρος αφορά τις εμπειρίες σας στο **δημοτικό σχολείο (6-11)**

Οι επόμενες ερωτήσεις αφορούν τις **σωματικές μορφές εκφοβισμού**

* 122. Κατά την διάρκεια του δημοτικού, έτυχε να υποστείτε κάποιον από τους ακόλουθους τρόπους σωματικού εκφοβισμού;

- ☐ Να δεχτείτε χτυπήματα/γροθιές
- ☐ Να σας κλέψουν προσωπικά αντικείμενα
- ☐ Κανένα από τα δυο

* 123. Αυτό συνέβαινε..

- ◯ Ποτέ
- ◯ Σπάνια
- ◯ Μερικές φορές
- ◯ Συχνά
- ◯ Συνεχώς

* 124. Πόσο σοβαρά θεωρείτε αυτά τα περιστατικά;

- ◯ Δεν μου έχει συμβεί ποτέ
- ◯ Καθόλου σοβαρά
- ◯ Κάπως σοβαρά
- ◯ Αρκετά σοβαρά
- ◯ Εξαιρετικά σοβαρά

Οι επόμενες ερωτήσεις αφορούν τις **λεκτικές μορφές εκφοβισμού**

* 125. Κατά την διάρκεια του δημοτικού, έτυχε να υποστείτε κάποιον από τους ακόλουθους τρόπους λεκτικού εκφοβισμού;

- ☐ Να σε προσφωνήσουν με κακόβουλα ονόματα
- ☐ Να σε απειλήσουν
- ☐ Κανένα από τα δυο

* 126. Αυτό συνέβαινε..

- ◯ Ποτέ
- ◯ Σπάνια
- ◯ Μερικές φορές
- ◯ Συχνά
- ◯ Συνεχώς

* 127. Πόσο σοβαρά θεωρείτε αυτά τα περιστατικά;

- ◯ Δεν μου έχει συμβεί ποτέ
- ◯ Καθόλου σοβαρά
- ◯ Κάπως σοβαρά
- ◯ Αρκετά σοβαρά
- ◯ Εξαιρετικά σοβαρά

Οι επόμενες ερωτήσεις αφορούν τις **έμμεσες μορφές εκφοβισμού**

* 128. Κατά την διάρκεια του δημοτικού, έτυχε να υποστείτε κάποιον από τους ακόλουθους τρόπους εκφοβισμού;

- ☐ Να έχουν πει ψέματα για εσάς
- ☐ Να σας αποκλείσουν από την παρέα
- ☐ Κανένα από τα δυο

* 129. Αυτό συνέβαινε..

- ◯ Ποτέ
- ◯ Σπάνια
- ◯ Μερικές φορές
- ◯ Συχνά
- ◯ Συνεχώς

* 130. Πόσο σοβαρά θεωρείτε αυτά τα περιστατικά;

- ◯ Δεν μου έχει συμβεί ποτέ
- ◯ Καθόλου σοβαρά
- ◯ Κάπως σοβαρά
- ◯ Αρκετά σοβαρά
- ◯ Εξαιρετικά σοβαρά

Οι επόμενες ερωτήσεις αφορούν τον εκφοβισμό **γενικότερα**

* 131. Εάν σας έχουν συμβεί κάποια από τα παραπάνω περιστατικά, πόσο καιρό κράτησαν;

- ◯ Δεν μου έχουν συμβεί ποτέ
- ◯ Μερικές ημέρες
- ◯ Εβδομάδες
- ◯ Μήνες
- ◯ Ένα χρόνο ή περισσότερο

* 132. Εάν έχουν συμβεί κάποια από τα παραπάνω περιστατικά, συνήθως από πόσους μαθητές γίνονταν;

- ◯ Δεν μου έχουν συμβεί ποτέ
- ◯ Κυρίως ένα αγόρι
- ◯ Αρκετά αγόρια
- ◯ Κυρίως ένα κορίτσι
- ◯ Αρκετά κορίτσια
- ◯ Και αγόρια και κορίτσια

ΜΕΡΟΣ 2: Αυτό το μέρος αφορά τις εμπειρίες σας στο **γυμνάσιο και λύκειο (12-18)**

Οι επόμενες ερωτήσεις αφορούν τις **σωματικές μορφές εκφοβισμού**

* 133. Κατά την διάρκεια του γυμνάσιου ή και του λυκείου, έτυχε να υποστείτε κάποιον από τους ακόλουθους τρόπους σωματικού εκφοβισμού;

- ☐ Να δεχτείτε χτυπήματα/γροθιές
- ☐ Να σας κλέψουν προσωπικά αντικείμενα
- ☐ Κανένα από τα δυο

* 134. Αυτό συνέβαινε..

- ◯ Ποτέ
- ◯ Σπάνια
- ◯ Μερικές φορές
- ◯ Συχνά
- ◯ Συνεχώς

* 135. Πόσο σοβαρά θεωρείτε αυτά τα περιστατικά;

- ◯ Δεν μου έχει συμβεί ποτέ
- ◯ Αρκετά σοβαρά
- ◯ Καθόλου σοβαρά
- ◯ Εξαιρετικά σοβαρά
- ◯ Κάπως σοβαρά

Οι επόμενες ερωτήσεις αφορούν τις **λεκτικές μορφές εκφοβισμού**

* 136. Κατά την διάρκεια του γυμνάσιου ή και του λυκείου, έτυχε να υποστείτε κάποιον από τους ακόλουθους τρόπους λεκτικού εκφοβισμού;

- ☐ Να σας προσφωνήσουν με κακόβουλα ονόματα
- ☐ Να σας απειλήσουν
- ☐ Κανένα από τα δυο

* 137. Αυτό συνέβαινε..

- ◯ Ποτέ
- ◯ Συχνά
- ◯ Σπάνια
- ◯ Συνεχώς
- ◯ Μερικές φορές

* 138. Πόσο σοβαρά θεωρείς αυτά τα περιστατικά;

- ◯ Δεν μου έχει συμβεί ποτέ
- ◯ Αρκετά σοβαρά
- ◯ Καθόλου σοβαρά
- ◯ Εξαιρετικά σοβαρά
- ◯ Κάπως σοβαρά

Οι επόμενες ερωτήσεις αφορούν τις **έμμεσες μορφές εκφοβισμού**

* 139. Κατά την διάρκεια του γυμνάσιου ή και του λυκείου, έτυχε να υποστείτε κάποιον από τους ακόλουθους τρόπους εκφοβισμού;

- ☐ Να έχουν πει ψέματα για εσάς
- ☐ Να σας αποκλείσουν από την παρέα
- ☐ Κανένα από τα δυο

* 140. Αυτό συνέβαινε..

- ◯ Ποτέ
- ◯ Συχνά
- ◯ Σπάνια
- ◯ Συνεχώς
- ◯ Μερικές φορές

* 141. Πόσο σοβαρά θεωρείτε αυτά τα περιστατικά;

- ◯ Δεν μου έχει συμβεί ποτέ
- ◯ Αρκετά σοβαρά
- ◯ Καθόλου σοβαρά
- ◯ Εξαιρετικά σοβαρά
- ◯ Κάπως σοβαρά

Οι επόμενες ερωτήσεις αφορούν τον **εκφοβισμό γενικότερα**

* 142. Εάν σας έχουν συμβεί κάποια από τα παραπάνω περιστατικά, πόσο καιρό κράτησαν;

- ◯ Δεν μου έχουν συμβεί ποτέ
- ◯ Μήνες
- ◯ Μερικές ημέρες
- ◯ Ένα χρόνο ή περισσότερο
- ◯ Εβδομάδες

* 143. Εάν έχουν συμβεί κάποια από τα παραπάνω περιστατικά, συνήθως από πόσους μαθητές γίνονταν;

- ◯ Δεν μου έχουν συμβεί ποτέ
- ◯ Κυρίως ένα κορίτσι
- ◯ Κυρίως ένα αγόρι
- ◯ Αρκετά κορίτσια
- ◯ Αρκετά αγόρια
- ◯ Και αγόρια και κορίτσια

ΜΕΡΟΣ 3

* 144. Την περίοδο που δεχόσασταν εκφοβισμό, μήπως σκεφτήκατε ποτέ να αυτοτραυματιστείτε ή να πάρετε την δική σας ζωή;

- ◯ Δεν ήμουν θύμα εκφοβισμού
- ◯ Όχι, ποτέ
- ◯ Ναι, μια φορά
- ◯ Ναι, περισσότερο από μια φορά

* 145. Έχετε υποστεί εκφοβισμό με κάποιον από τους παραπάνω τρόπους, μετά που τελειώσατε το σχολείο;

- ◯ Δεν μου έχει συμβεί ποτέ
- ◯ Ναι, από την οικογένειά μου
- ◯ Ναι, από άλλους (παρακαλώ διευκρινίστε)

APPENDIX C

Email for participants meeting phase two criteria

Γεια σας,

Ελπίζω αυτό το μήνυμα να σας βρίσκει καλά.

Σας στέλνω σχετικά με την έρευνα με όνομα **«Η Εξέταση της Σχέσης Μεταξύ της Εμπειρίας του Σχολικού Εκφοβισμού στην Παιδική Ηλικία και της Ανάπτυξης Διαταραγμένων Διατροφικών Συμπεριφορών»** στην οποία έχετε λάβει μέρος μέσω του SurveyMonkey.

Με βάση τις απαντήσεις σας στο ερωτηματολόγιο της 1ης φάσης έχετε επιλεγεί απο τους ερευνητές να λάβετε μέρος στην 2η φάση της έρευνας η οποία αποτελείται από μια ημιδομημένη συνέντευξη η οποία θα γίνει μέσω τηλεδιάσκεψης (π.χ. ZOOM, Skype etc).

Εάν ενδιαφέρεστε να συμμετάσχετε στην 2η φάση παρακαλώ απαντήστε σε αυτό το email για να προγραμματίσουμε την ημερομηνία που σας βολεύει για να γίνει η συνέντευξη. Θα το εκτιμούσαμε ιδιαίτερα αν μπορούσατε να μας αφιερώσετε λίγο από τον χρόνο σας αφού η συμμετοχή σας θα προσφέρει πολύτιμες γνώσεις που μπορούν να συμβάλλουν στην ανάπτυξη στοχευμένων παρεμβάσεων για την μείωση του κινδύνου ανάπτυξης διατροφικών διαταραχών στους νέους.

Πιο κάτω θα βρείτε συνημμένο το έντυπο συγκατάθεσης το οποίο περιέχει περισσότερες πληροφορίες για την παρούσα έρευνα.

Για οποιαδήποτε περαιτέρω πληροφορία ή διευκρίνιση, παρακαλώ μην διστάσετε να επικοινωνήσετε μαζί μας.

Ευχαριστώ εκ των προτέρων,

Μαρία Μάρκου

APPENDIX D

Consent form for the qualitative phase

ΕΝΤΥΠΟ ΣΥΓΚΑΤΑΘΕΣΗΣ

(2Η ΦΑΣΗ)

Η Εξέταση της Σχέσης Μεταξύ της Εμπειρίας του Σχολικού Εκφοβισμού στην Παιδική Ηλικία και της Ανάπτυξης Διαταραγμένων Διατροφικών Συμπεριφορών στην Αναδυόμενη Ενηλικίωση: Μεθοδολογία Μεικτής Προσέγγισης

Στο έντυπο αυτό δίνονται εξηγήσεις σε απλή και κατανοητή γλώσσα σχετικά με το τι ζητείται από εσάς ή/και τι θα συμβεί σε εσάς, εάν συμφωνήσετε να συμμετάσχετε στο πρόγραμμα:

1. Περιγράφονται οποιοιδήποτε κίνδυνοι μπορεί να υπάρξουν ή ταλαιπωρία που τυχόν θα υποστείτε από την συμμετοχή σας στο πρόγραμμα.
2. Επεξηγείται με κάθε λεπτομέρεια ποιος ή ποιοι θα έχουν πρόσβαση στα δεδομένα που σας αφορούν και θα προκύψουν από το πρόγραμμα που θα συμμετάσχετε ή/και άλλο υλικό/δεδομένα που εθελοντικά θα δώσετε για το πρόγραμμα.
3. Δίνεται η χρονική περίοδος για την οποία οι υπεύθυνοι του προγράμματος θα έχουν πρόσβαση στις πληροφορίες ή/και υλικό σας αφορά.
4. Επεξηγείται το τί ευελπιστούν να μάθουν οι υπεύθυνοι του προγράμματος σαν αποτέλεσμα και της δικής σας συμμετοχής.
5. Δίνεται μία εκτίμηση για το όφελος που μπορεί να υπάρξει για τους ερευνητές ή/και χρηματοδότες αυτού του προγράμματος.
6. Δεν πρέπει να συμμετάσχετε, εάν δεν επιθυμείτε ή εάν έχετε οποιουσδήποτε ενδοιασμούς που αφορούν τη συμμετοχή σας στο πρόγραμμα.
7. Είστε ελεύθεροι να αποσύρετε οποιαδήποτε στιγμή εσείς επιθυμείτε τη συγκατάθεση για την συμμετοχή σας στο πρόγραμμα.
8. Πρέπει όλες οι σελίδες των εντύπων συγκατάθεσης να φέρουν το ονοματεπώνυμο και την υπογραφή σας.

Α. Σύντομη περιγραφή έρευνας

Τα ποσοστά διαταραγμένων διατροφικών συμπεριφορών στους νέους έχουν αυξηθεί σημαντικά τα τελευταία χρόνια. Γι' αυτό τον λόγο, ο εντοπισμός συγκεκριμένων παραγόντων που μπορούν να βοηθήσουν στην ανάπτυξη στοχευμένων παρεμβάσεων για την μείωση του κινδύνου ανάπτυξης διαταραγμένων διατροφικών συμπεριφορών, καθώς και διατροφικών διαταραχών στους νέους είναι σημαντικός. Παρόλο που στην βιβλιογραφία είναι γνωστό ότι ο σχολικός εκφοβισμός στην παιδική ηλικία αποτελεί ένα από τους σημαντικότερους παράγοντες κινδύνου για την ανάπτυξη διατροφικών διαταραχών και διαταραγμένων διατροφικών συμπεριφορών, οι γνώσεις που έχουμε για τις μακροχρόνιες επιπτώσεις του σχολικού εκφοβισμού, συγκεκριμένα στην ανάπτυξη διαταραγμένων διατροφικών συμπεριφορών στην αναδυόμενη ενηλικίωση (18-25 ετών), αλλά και για τυχών άλλους παράγοντες που μπορεί να επηρεάζουν αυτή την σχέση είναι περιορισμένες.

Έτσι, η παρούσα έρευνα επιδιώκει να διερευνήσει τους παράγοντες που συμβάλλουν στην ανάπτυξη τριών διαφορετικών τύπων διαταραγμένων διατροφικών συμπεριφορών στην αναδυόμενη ενηλικίωση.

Β. Συμμετοχή στην έρευνα

Οι στόχοι της παρούσας έρευνας πρόκειται να επιτευχθούν μέσα από δυο ξεχωριστές φάσεις. Στην πρώτη φάση της έρευνας σας ζητήθηκε να συμπληρώσετε ερωτηματολόγια αυτοαναφοράς που αφορούσαν δημογραφικά χαρακτηριστικά, τις διατροφικές σας συμπεριφορές, τις ικανότητες ρύθμισης των συναισθημάτων σας και την εμπειρία σας σχετικά με σχολικό εκφοβισμό στην παιδική ηλικία.

Με βάση τις απαντήσεις σας στα ερωτηματολόγια της 1ης φάσης επιλέξαμε να σας καλέσουμε να λάβετε μέρος στην 2η φάση της έρευνας η οποία αποτελείτε από μια ημιδομημένη συνέντευξη.

Η συμμετοχή σας στην παρούσα έρευνα είναι εθελοντική. Ο κάθε συμμετέχοντας έχει το δικαίωμα να άρει την συμμετοχή του στην έρευνα ανά πάσα στιγμή το θελήσει χωρίς κάποια συνέπεια (κατά την διάρκεια της συνέντευξης, καθώς και μετά το τέλος συνέντευξης).

Επίσης, έχετε το δικαίωμα να αρνηθείτε να απαντήσετε σε οποιεσδήποτε ερωτήσεις δεν επιθυμείτε να απαντήσετε και να παραμείνετε στην έρευνα.

Αν επιθυμείτε να αποχωρήσετε από την έρευνα παρακαλώ επικοινωνήστε με την Μαρία Μάρκου, υπεύθυνη ερευνητή της παρούσας έρευνας, στην ηλεκτρονική διεύθυνση markou.p.maria@ucy.ac.cy. Εναλλακτικά, μπορείτε να επικοινωνήσετε με τον Δρ. Παναγιώτης Σταυρινίδη, επιστημονικό υπεύθυνο της παρούσας έρευνας, στην ηλεκτρονική διεύθυνση stavrini@ucy.ac.cy ή στο 22892073.

Γ. Πληροφορίες σχετικά με την συνέντευξη της 2ης φάσης

Κατά την διάρκεια της συνέντευξης θα υπάρξουν ερωτήσεις σχετικά με τις διατροφικές σας συμπεριφορές στο παρόν και το παρελθόν και την εμπειρία σας με τον εκφοβισμό στην παιδική ηλικία.

Δ. Αναμενόμενο όφελος για τους συμμετέχοντες

Δεν θα υπάρξουν προσωπικά οφέλη από την συμμετοχή σου σε αυτή την έρευνα. Ωστόσο, η συμμετοχή σου θα προσφέρει πολύτιμες γνώσεις που μπορούν να συμβάλλουν στην ανάπτυξη στοχευμένων παρεμβάσεων για την μείωση του κινδύνου ανάπτυξης διαταραγμένων διατροφικών συμπεριφορών, καθώς και διατροφικών διαταραχών στους νέους.

Ε. Πιθανοί κίνδυνοι ή ταλαιπωρία που τυχόν να υπάρξουν

Δεν υπάρχουν προβλέψιμοι κίνδυνοι που προκύπτουν από τη συμμετοχή σας στην παρούσα έρευνα. Ωστόσο, είναι σημαντικό να αναφερθεί ότι υπάρχει κίνδυνος να αισθανθείτε άσχημα ή/και να νιώσετε ότι φορτίζεστε ψυχολογικά διαβάζοντας (1η φάση) ή μιλώντας (2η φάση) για τα θέματα που αφορούν την παρούσα έρευνα λόγω του ευαίσθητου της περιεχομένου.

ΣΤ. Πρόσβαση και διαφύλαξη δεδομένων

Η συνέντευξη θα μαγνητοφωνηθεί για σκοπούς ανάλυσης των δεδομένων που θα συλλεχθούν. Το ακουστικό αρχείο θα διαφυλάσσεται σε ντουλάπι ασφαλείας (με κωδικό πρόσβασης) στο γραφείο του ερευνητή όπου μόνο η ερευνητής θα έχει πρόσβαση. Ο επιστημονικός υπεύθυνος (Δρ. Παναγιώτης Σταυρινίδης) θα έχει πρόσβαση μόνο στα ανώνυμα δεδομένα.

Το ακουστικό αρχείο από τον κάθε συμμετέχοντα θα καταστραφεί αμέσως μετά την απομαγνητοφώνησή του. Η απομαγνητοφώνηση θα ολοκληρωθεί σε διάστημα δυο εβδομάδων από την ολοκλήρωση της συνέντευξης.

Ζ. Στοιχεία επικοινωνίας

Υπεύθυνος Υπηρεσίας Υποστήριξης Έρευνας
Δρ. Μάριος Δημητριάδης
Πανεπιστήμιο Κύπρου
demetriades.a.marios@ucy.ac.cy
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Επιστημονικός Υπεύθυνος
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Ερευνήτρια
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Διδακτορική Φοιτήτρια
Τμήμα Ψυχολογίας, Πανεπιστήμιο Κύπρου
markou.p.maria@ucy.ac.cy

Η. Πληροφορίες για υπηρεσίες ψυχολογικής στήριξης

Τηλεφωνική Υπηρεσία Συμβουλευτικής & Στήριξης
(Οργανισμός Νεολαίας Κύπρου)
Τηλ. 1410

Συμβουλευτική Μέσω Διαδικτύου
(Οργανισμός Νεολαίας Κύπρου)
https://onek.org.cy

Κέντρο Ψυχικής Υγείας Πανεπιστήμιο Κύπρου
Κέντρο Υγείας (Κτήριο ΚΟΔ06), Ισόγειο,

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Κέντρο Υγείας Ιδαλίου
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Αγροτικό Υγειονομικό Κέντρο Παλιομετόχου
Τηλ. +357 22952459

Αγροτικό Υγειονομικό Κέντρο Ακακίου
Τηλ. +357 22821080

Επίθετο: _____ Όνομα: _____

Υπογραφή: _____ Ημερομηνία: _____

APPENDIX E

Interview Protocol

A. Existence of identity pathology

Αρχικά θα ήθελα να μάθω κάποια πράγματα για εσένα για να σε γνωρίσω καλύτερα

1. Πες μου λίγα λόγια για εσένα επικεντρώνοντας κυρίως στο χαρακτήρα και την προσωπικότητά σου

B. Experience of DEBs

2. Πρώτα θα ήθελα να μου περιγράψεις πως καταλαβαίνεις την λέξη διαταραγμένη διατροφική συμπεριφορά
3. Μπορείς να περιγράψεις τις διατροφικές σου συνήθεις αυτή την περίοδο;
4. Πότε περίπου, εάν θυμάσαι, ξεκίνησαν αυτές οι συμπεριφορές;
5. Πότε θα έλεγες ότι ήταν η πρώτη φορά που συνειδητοποίησες ότι αυτές οι συμπεριφορές επηρέασαν την καθημερινότητά σου;
6. Θυμάσαι εάν γινόταν κάτι συγκεκριμένο εκείνη την περίοδο που ξεκίνησαν αυτές οι συμπεριφορές;
7. Υπάρχουν συγκεκριμένες καταστάσεις που σε οδηγούν πιο εύκολα στις διατροφικές συμπεριφορές που περιέγραψες πιο πάνω;
    - Αν ναι, ποιες είναι αυτές; Μπορεί να είναι εσωτερικά ερεθίσματα (π.χ. συγκεκριμένες σκέψεις/συγκεκριμένα συναισθήματα) ή εξωτερικά ερεθίσματα (π.χ. συγκεκριμένα άτομα/περιβάλλον κτλ.)
8. Ποιος πιστεύεις είναι ο ρόλος αυτών των συμπεριφορών στην ζωή σου?
9. Τι συναισθήματα σου προκαλούν αυτές η συμπεριφορές;

C. Experience of CPV

10. Μπορείς να μου πεις λίγα λόγια για την εμπειρία σου με τον εκφοβισμό στην παιδική ηλικία;

    α. Πότε έγινε πρώτη φορά;

    β. (Αν έγινε περισσότερο από 1 φορά) Που συνέβαινε συνήθως;

    γ. Τι είδους εκφοβισμός ήταν;

    δ. Πόσο συχνά συνέβαινε;

    ε. Από πόσα άτομα;

    στ. Πως αντιδρούσες συνήθως στον εκφοβισμό που δεχόσουν;

    ζ. Πόσο καιρό κράτησε ο εκφοβισμός;

    η. Άλλαξε σε μορφή;

    θ. Πόσο σοβαρό θεωρούσες ότι ήταν τότε;

11. Πιστεύεις ότι ο εκφοβισμός που βίωσες επηρέασε με κάποιο τρόπο τις διατροφικές συνήθεις που έχεις τώρα;

12. Πιστεύεις ότι αν δεν υπήρχε ο εκφοβισμός θα έβλεπες διαφορετικά τον εαυτό σου;

D. Emotions

13. Πως αντιδράς συνήθως στο:
    α. Θυμό
    β. Λύπη
    γ. Άγχος

E. Family environment and eating behaviours while growing up

(Διατροφικές συνήθεις στην παιδική ηλικία)

14. Όταν ήσουν παιδί πως θα περιέγραφες:
    α. Το βάρος σου;
    β. Την σχέση σου με το φαγητό;
    γ. Τις διατροφικές σου συνήθειες;

15. Υπήρχαν κανόνες είτε εντός της οικογένειας σχετικά με το φαγητό όταν μεγάλωνες; (π.χ. ώρα φαγητού, απαγορευμένες τροφές, μέρες για συγκεκριμένα φαγητά)

    Διατροφικές συνήθεις στην οικογένεια

16. Έχει κάποιο μέλος της οικογένειάς σου το οποίο παρουσιάζει υπερβολική ανησυχία για το βάρος του, το φαγητό ή την εξωτερική του εμφάνιση γενικότερα;

    Στάση οικογένειας προς εξωτερική εμφάνιση ατόμου

17. Σε μερικές οικογένειες, υπάρχει μεγάλη έμφαση στην εξωτερική εμφάνιση. Λαμβάνοντας υπόψη την οικογένειά σου, πώς θα αξιολογούσες τη σημασία που έδινε η οικογένειά σου στην εξωτερική εμφάνιση;

18. Άλλαξε κάτι σήμερα σχετικά με τα πιο πάνω που μου ανέφερες;