

CHARACTERISTICS AND FUNCTIONS OF SELF-DEFINING MEMORIES IN
RESTRAINED EATERS

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CHARACTERISTICS AND FUNCTIONS OF SELF-DEFINING MEMORIES IN
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DECLARATION OF ORIGINALITY

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ABSTRACT

Characteristics and Functions of Self-Defining Memories in Restrained Eaters

The main purpose of the present study was to investigate the characteristics and functions of self-defining memories (SDM) in restrained eaters in terms of eating attitudes. To this end the content, specificity, integration, emotional valence and functions (self, social and directive) of SDMs were analyzed by controlling for depression and alexithymia. Participants were divided into low- and high groups according to their Eating Disorder Examination Questionnaire (EDE-Q) scores. Each participant retrieved three SDMs. No main effect was found in SDM characteristics. There was also no difference between groups with low- and high groups in terms of content, specificity, emotion, and integration of memories. On the other hand, groups were different in terms of the functions of SDMs. First, low eating-concern group had higher scores for directive function than the high eating group for their first SDMs. Secondly, low shape-concern group had higher average (of three SDMs) self and directive function scores than high group. Finally, we observed a reverse pattern for average social function scores; high shape concern group had higher social function scores for both average and first SDMs.

ÖZET

Yeme Davranışını Kısıtlayan Kişilerde Benlik-Tanımlayıcı Anıların Özellikleri ve İşlevleri

Bu araştırmanın amacı, yeme davranışını kısıtlayan katılımcılarda benlik-tanımlayıcı anıların (BTA) özelliklerini yeme tutumlarına göre araştırmaktır. Bu amaçla BTA'ların, özgüllüğü, bütünlüğü, duygusal değeri ve işlevi (benlik, sosyal, ve yönlendirici işlevi), depresyon ve aleksitimi kontrol edilerek analiz edildi.

Katılımcılar, Yeme Bozukluğu Anketi'nden aldıkları puanlara göre yüksek/düşük yeme bozukluğu gruplarına ayrıldılar. Her katılımcı üç BTA hatırladı. Benlik tanımlayıcı anıların özelliklerinin temel etkisi bulunmadı. Yüksek ve düşük yeme bozukluğu olan gruplar arasında, anıların içeriği, özgüllüğü, duygu değeri ve bütünlüğü açısından da bir fark bulunmadı. Öte yandan gruplar, benlik tanımlayıcı anıların işlevi açısından farklılaştı. İlk olarak, yemek yeme davranışı hakkında az endişe eden grubun anılarındaki yönlendirici işlev puanları, yemek yeme davranışı hakkında çok endişe eden grubun puanlarından daha yüksek çıktı. İkinci olarak, beden şekli hakkında az endişe eden grubun üç anıya ait ortalama benlik ve yönlendirici işlev puanları, beden şekli hakkında çok endişe eden grubunkinden yüksek çıktı. Sosyal işlev puanları açısından ise bunun tersi bir sonuç gözlemlendi: Beden şekli hakkında çok endişe eden grubun sosyal işlev puanları hem üç anının ortalamasında hem de ilk benlik tanımlayıcı anıda, beden şekli hakkında az endişelenen grubunkinden yüksek çıktı.

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CHAPTER 1

THEORETICAL BACKGROUND

Although we quickly forget our many memories some others affect our life profoundly. The later ones are mostly related to *self*. A special kind of these memories are called self defining memories (SDMs). Self-defining memory a kind of autobiographical memory, which defines what kind of a people we are. The main purpose of the present study is to explore the *functions* and *characteristics* of self-defining memories (SDMs) in restrained eaters. In this context “function” indicates the motivation and reason for remembering a certain memory (Harris, Rasmussen, & Berntsen, 2014). People benefit from their autobiographical memories in several ways throughout their lives such as starting a conversation or planning future (e.g., Bluck & Alea, 2008; Conway & Pleydell-Pearce, 2000).

There are three major approaches on this issue; *Reminiscence Approach* (e.g., Webster, 1993), the *Three Function Model* (e.g., Bluck, Alea, Habermas, & Rubin, 2005), and more integrated approaches (e.g., Harris, Rasmussen, & Bernsten, 2014). Although these approaches theoretically differ in some respects they commonly try to shed light on the function of autobiographical memories in our daily live.

The three-function model is a cognitive approach to SDMs, and based upon self, social and directive functions of autobiographical memories (e.g. Cohen, 1998; Pillemer, 1992). First, self or identity function of ABMs is crucial since it provides information about “who we are?”. That is our self-knowledge. It helps us to construct and maintain a coherent self over time (e.g., Conway, 1996). An important stipulation for being psychologically healthy is the feeling or experiencing of continuity over time (e.g., Bluck, 2003). This experience is provided by our

autobiographical memories. The relation between self and memories has been exploring over 40 years (e.g., Bluck et al., 2008; Brewer, 1986). Our self-knowledge integrates our past ABMs and organizes our “self-system” (e.g., Bluck & Habermas, 2001; Bluck et al., 2008, p. 4) which in turn forms *life story* (e.g., Mc Adams, 1990). This process occurs without any deliberate effort (e.g., Bluck et al., 2008).

The second function of ABMs is social one (e.g., Alea & Bluck, 2003; Pillemer, 1998). Relating our some memories reciprocally helps us to build and maintain close social relationships (e.g., Thorne, Cutting, & Skaw, 1998). These relationships enable us to be aware of others thoughts, feelings, and show empathy towards them (e.g., Cohen, 1998; Hyman & Faries, 1992; Pillemer, 1998; Webster, 1993). Finally, directive function of ABMs is related to problem solving (e.g., Harris et al., 2014; Pillemer, 2003). We usually take lessons from our past experiences and benefit from them to assess the present and to plan the future. A certain memory may function in many ways simultaneously (multifunctional). For example we can share a memory as an ice breaker in a new social context (social); it can also be related to an unpleasant experience that teaches us a lot (directive) and may also include self-defining aspects (self) (Bluck, 2003).

Although three-function model is mostly referred to explain ABMs, researchers point out that its implications about how people use their ABMs in daily life is not strong enough (e.g., Rasmussen & Berntsen, 2010). Unlike the three-function model, the reminiscence approach, as an alternative approach, depends on psychodynamic perspective. Reminiscence approach focuses on individual differences more than any other approaches to explain the function of ABMs. According to this approach, there are eight different functions of ABMs: problem solving, identity, conversation, boredom reduction, intimacy maintenance, death

preparation, teach/inform and bitterness revival. Each of them is developed from empirical and theoretical work using a “bottom-up” technique (e.g., Harries et al., 2014, p. 561; Cappeliez, O’Rourke & Chadbury, 2005; Webster, 1994.). In this technique the participants are asked to answer some open-ended questions about the reason and motivation for remembering their memories. Later Webster (2003) suggested that these eight different functions can be categorized in two groups by a factor analysis; social function vs self-oriented function; and reactive/loss oriented function vs proactive/growth oriented function.

Besides these two main approaches, there is another one called integrative approach which aims at combining existing models into four-function model of Harris et al. (2014). In their model Harris et al. (2014) attempted to explain how the different approaches can be integrated. As a result four main functions of ABMs are labeled as reflective, generative, ruminative, and social functions.

1.1 Characteristics of ABMs in psychopathology

Although each of these models differs in theoretical basis they all suggest ‘self’ play a crucial role in ABMs. Self is formed by our past experiences (e.g., Conway, 2005). Our self-image and goals have a great impact on retrieving specific memories (Conway et al., 2000). In order to investigate the relation between self and ABMs in a more efficient way Singer and Moffitt (1991,1992) offered a new perspective called as “self-defining memory”. Self-defining memories (SDMs) are highly related to our personality and self-characteristics, and are indispensable part of our life story. They are vivid, emotionally intense, and easily retrievable. Because of their close relation to our self, they are affected by our concerns, conflicts, and long-term goals (e.g., Singer, Rexhaj, & Baddeley, 2007; Moffitt & Singer, 1994). Furthermore, as in

ABMs, we relate our SDMs to talk about our life and ourselves to maintain more intimate relationships. SDMs are also important for our self-knowledge (e.g., McLean & Thorne, 2003). For this reason, exploring SDMs in psychological diseases may shed light on both clinical and cognitive psychology.

Any research of SDMs in behavioral disorders again may help us to gain insight into how any self-related disturbance alters the pattern of our memories (e.g., Maccallum & Bryant, 2008). The SDMs are also used to reveal the relationship between meaning-making (MM) and development of personality (Blagov & Singer, 2004). Reminiscing any memory is affected by our current self and goals which may be deteriorated during traumatic events such as divorce (e.g., King & Raspin, 2004) or loosing a loved one (e.g., Maccallum et al., 2008; Sutherland & Bryant, 2005). According to Berntsen (2001), such unpleasant life-changing experiences change the pattern of our autobiographical knowledge and constitutes the base of the self-system. It is well known that the most severe alterations in the pattern of SDMs are observed in behavioral disorders as indicated below.

There are many studies that investigate the characteristics of SDMs in various behavioral disorders such as schizophrenia (e.g., Berna, Bennouna-Greene, Potheegadoo, Verry, Conway, & Danion, 2011a, b; Raffard, D'Argembeau, Lardi, Bayard, Boulenger, & van der Linden, 2009, 2010), depression (e.g., Moffitt et al, 1994; Werner-Seidler & Moulds, 2012, 2014; Folland-Ross, Cooney, Joormann, Henry, & Gotlib, 2014), borderline personality disorder (e.g., Jorgensen, Berntsen, Bech, Kjølbye, Bennedsen, & Ramsgaard, 2012; Guruprasad & Bhola, 2014), post-traumatic stress disorder (e.g., Jobson & O'Kearney, 2008), dysphoria (e.g., Romero, Vazquez, & Sanchez, 2014), or in repression-prone (e.g., Lardi, Ghisletta,

& van der Linden, 2012), and hypomania-prone individuals (e.g., Robyn, Ghisletta, & van der Linden, 2012).

Schizophrenia is one of the most investigated psychological disorders in self-defining memory. The continuity of self throughout life is very important to remember past and to imagine the future (e.g., Wheeler, Stuss, & Tulving, 1997). Since this process is impaired in the patients mentioned above their self-concept is highly distorted (e.g., Raffard et al., 2009). Raffard et al.'s (2009, 2010) results indicate that schizophrenics' SDMs are less integrated; their memory content has more *hospitalization/stigmatization* and *failure* categories than healthy controls', and their reminiscence bump peak is between 15 and 19 years old. They also experience more life-threatening events, have trouble with benefit from experiences and generate meaningful personal life narratives (e.g., Raffard et al., 2009, 2010). The underlying mechanisms of these issues are considered as the patients' impaired personal continuity (e.g., Bleuler, 1950) and the weak association between memories and behaviors (e.g., McAdams, 1990). A probable reason underlying abnormal reminiscence bump between 15 and 19 years of age may be related to the fact that they are diagnosed with schizophrenia during this period. (e.g., Raffard et al., 2009, 2010).

Berna et al. (2011a, 2011b) focused on integration and meaning making (MM). Their findings are in line with those of Raffard et al.'s (2009, 2010). The mechanisms underlying these issues are related to impaired metacognitive, updating and executive functions (e.g., Lysaker, Warman, Dimaggio, Procacci, LaRocco, Clark et al., 2008).

Behavioral disorders may have some other effects on self-defining memory such as less specific memories in depressed people, and inability to use positive

memories for mood repair in abstract processing (e.g., Moffitt et al., 1994; Werner-Seidler et al., 2012). The mechanisms underlying these problems are that depressive patients have difficulty with moving from a general level to a specific level of personal memories (e.g., Moore, Watts, & Williams, 1988), and their mood regulation problems (Werner-Seidler et al., 2012). Depression is related to emotional dysregulation and maladaptive coping strategies such as rumination and suppression of emotions (Garnefski & Kraaij, 2006). Borderline Personality Disorder patients' SDMs are less specific, less integrated, and emotion valence of these memories are often negative as in depressed patients. Their memories also include less normative events due to their distorted self-image (e.g., Jorgensen et al., 2012). The SDMs of PTSD patients include trauma-related events, and have high negative valence. The personal goals and current concerns of the patients mentioned in their memories are also related to trauma (e.g., Sutherland, 2005). According to reports by PTSD patients, trauma becomes a part of their self-construct (Bernsten, Willert, & Rubin, 2003).

Repression-prone individuals' SDMs are specific but non-integrated and their self-threatened SDMs contain less negative words. Defensiveness is correlated with less self-pronouns and failure content in memories (e.g., Lardi et al., 2012). These results are the consequence of the general behavior pattern of these individuals (e.g. Weinberger, 1990). On the other hand, hypomania-prone individuals report less specific, more integrated SDMs. Furthermore, their SDMs include more relationship and less achievement content. These characteristics stem from their stressful childhood period. Hypomania-prone individuals internalize the stressful life events from their childhood and integrate them to their current self (Lardi et al., 2012; Berntsen et al., 2003).

Although the characteristics of SDMs were investigated in various behavioral disorders literature, to our knowledge, none of them considered the function of SDMs. Because eating disorder patients suffered from self-impairment (e.g. Stein & Corte, 2008), it is probable that the characteristics and functions (self, social, and directive functions) of SDMs would be different in these patients.

1.2 Characteristics of ABMs in eating disorder patients

Several cognitive deficits are observed in ED patients such as impaired abstract reasoning (e.g., Kaye, Bastiani, & Moss, 1995), visual-spatial ability, (e.g., Jones, Duncan, Brouwers, & Mirsky, 1991) and attention (Rieger, Schotte, Touyz, Beaumont, Griffiths, & Russel, 1998).

Cognitive impairments also include ABM deficits. However there are only a few studies that investigate the relationship between eating disorders and autobiographical memory. The first study on autobiographical memory deficit in eating disorder patients (BN and AN) was conducted by Dalgeish, Tchanturia, Serpell, Hems and Yiend et al. (2003) to explore self-reported childhood abuse. The findings revealed an over-general (non-specific) first memory. Furthermore, there was a positive correlation between over-general memories for negative cue words and self-reported childhood abuse. In another study conducted by Laberg and Andersson (2004) bulimia nervosa (BN) patients were compared to control group in terms of ABM characteristics by giving cue words with different emotional valence. BN patients retrieved more over-general memories than control group. Neither emotional valence of cue words nor level of depression had any effect on over-general memory pattern. However, the results of the study are questionable because the patients are in remission period. In order to enlighten this issue, another study

was conducted by Nandrino, Doba, Lesne, Christophe and Pezard (2006) in anorexia nervosa (AN) group. The results showed that duration of the illness is the main predictor of less specific ABMs regardless of the negativity of the emotional experiences. The mechanism underlying this tendency is an emotional dysregulation which makes difficult to recognize and express feelings in these patients (e.g., Eizaguirre, Cabezon, Alda, Olariaga, & Juaniz, 2004; Zonneville-Bender, Goozen, Cohen-Kettenis, & Elburg et al., 2002). Bomba, Marfone, Brivio, Oggiano and Broggi (2014) found out a similar pattern. In addition to positive and negative cue categories, Kovacs, Szabo and Paszthy (2011) added neutral cue category as a third one. They also considered the pleasantness ratings and date of ABMs. As in the findings mentioned above, they observed an over-general memory effect for positive, negative and neutral cue words. Date of the memories had no effect. The only significant result regarding the pleasantness ratings is that the neutral ABMs were rated as more unpleasant. The tendency for producing general memories are considered to be affected by parental abuse, depression (e.g., Dalgleish et al., 2003), and the duration of the illness (e.g., Bomba et al., 2014).

Over-general memories function as a cognitive avoidance strategy (e.g., Williams & Moulds, 2007) The CaR-FA-X model proposed by Williams, Barnhofer, Crane, Herman, and Watkins et al. (2007) puts forward that these patients are highly occupied with their self-image and weight. This leads to a continuous rumination on these matters. For this reason, the patients keep away from all the thoughts and memories that may cause unpleasant feelings. At this point, it should be noted that preferring general ABMs to specific ones is a useful strategy to keep away from disturbing memories related to eating problem. In other words, it is a cognitive coping strategy (Bomba et al., 2014). Williams (1996) put forward another

explanation on the issue; he suggests that because of the patients' emotional dysregulation impairment they retrieve less specific memory only to avoid negative emotions. However, all these approaches consider this tendency as a "cognitive avoidance" (e.g., Kovacs et al., 2011, p. 63).

1.3 The self-concept of eating disorder patients and restrained eating

Self-impairment affects autobiographical memory test (AMT) performances for eating disorder patients. Therefore, it may be said that AN patients have different self-concept from healthy groups. How may this difference lead to a difference in self-function of ABM for eating disorder patients? Before considering this issue, the self-concept will be discussed in terms of *identity-impairment model* (Stein & Corte, 2003).

According to this model our self-concept is an outcome of our memories, and remains stable throughout life. Since our self-concept is formed by our unique autobiographical past, individuals are different and unique. Self-schemas is another product of our memories. The number of schemas, their content, attitudes associated to them, and their accessibility change in terms of age, education level, current concerns, and psychopathology etc (e.g. Stein, (1995); Harter & Monsour, 1992; Cantor & Kihlstrom, 1987). Unlike the healthy group, the content of self-schemas in ED patients overwhelmingly consists of exercise and body weight, and these schemas are activated more frequently than others (e.g., Harter, 1990; Higgins & King, 1981). Consequently, this content becomes an indispensable part of their self-definition (Hooker & Kaus, 1992). The accessibility of each self-schema differs according to our expectations, current motivation, our needs, recency and frequency of the activation (e.g., Stein et al., 2008)

According to identity-impairment model (Stein & Corte, 2008), these patients have less positive self-schemas, and their body-weight self-schemas are much more accessible than others because of constant rumination on this subject. In addition, self-doubt, incompetence, low self-esteem and fear of losing control over their weight highly integrate into patients' self-schema. Again according to the same model, each stimulus in our environment is interpreted to at least a few schemas, whereas, ED patients use body-weight schemas more often to interpret these stimuli compared to healthy group. At the beginning, patients' coping strategies are intact, they try to suppress their narrow, negative, and weight related schemas on purpose. This is called as active process. Over time, this active suppressing process lessens and turns into a passive processing in which the stimulus takes control the whole interpretation process. For this reason, their coping style become less effective, and they often feel confused and frustrated (Stein & Corte, 2003, 2007; Corte & Stein, 2005). Their weight-related self-concept can be defined as a collection of shape and size related representation. Since these self-schemas are frequently activated, they affect various cognitive processes (Markus, Hamill & Sentis, 1987). This constantly activated self-schemas cause a mental fatigue for patients, and it becomes much more difficult to suppress shape, size and weight-related self-schemas over time.

The pattern described above caused a pathological eating behavior, and an over-control mechanism on eating is considered as a precursor to eating disorders in general. Therefore, such a process can also be observed in individuals who have not been diagnosed still. For this reason, this problematic cognitive process can also be seen in individuals who are not diagnosed yet. People who are prone to restrain their eating are expected to demonstrate a similar pattern of anorexia nervosa. For instance, Ball, Singer, Kemps and Tiggemann (2010) revealed that restrained eaters

also have difficulty with retrieving specific memories just as in ED patients. These individuals use the same coping strategy and retrieve non-specific memories to avoid eating and weight related thoughts (e.g., Williams et al., 2007). Another study conducted by Johannessen and Berntsen (2009) demonstrated that as in ED patients, dieters also evaluate eating and weight related memories as the core of their life due to current motivation for losing weight and related concerns.

1.4 Present study

The aim of the present study is to investigate the functions (self, social, and directive) and characteristics (specificity, integration, content, and emotional valence) of the SDMs in restrained eaters within the frame of self-impairment, narrow self-schema (e.g., Stein & Corte, 2008, 2007; Markus et al. 1987), and ABM deficits in ED patients (Ball, et al., 2010; Bomba et al., 2014; Kovacs et al., 2011; Laberg et al., 2004; Dalglish, et al., 2003; Nandrino, et al., 2006). Given that the characteristics of SDMs in the self-impaired patient groups with schizophrenia (REF) or PTSD (REF) are different from those of healthy groups, then it is expected that the SDMs of ED (and restrained eaters who incline to develop ED) would be different because of their self-impairment as we mentioned in identity impairment model (e.g., Stein et al., 2008). In the current study, this expectation was tested. To our knowledge, it is the first study which investigates the characteristics and functions of SDMs in a sub-clinical ED group. Secondly, and more importantly, this is the first study which explores the functions of SDMs in a sub-clinical group (restrained eaters). We also try to answer the question of whether the self, social, and directive functions of SDMs differ from healthy group.

First, the restrained eaters are expected to get lower scores on Thinking About Life Experiences scale (TALE-R) than healthy participants. Secondly, in line with the literature (e.g. Bomba et al., 2014; Nandrino et al., 2006), the retrieved SDMs are expected to demonstrate an over-general memory effect. Third, the content of the SDMs are expected to be mostly about weight-related content. Finally, because of emotional dysregulation, the emotional valence of SDMs are expected to be more neutral (e.g., Zonnevijle-Bender et al., 2004; Nandrino et al., 2006).

CHAPTER 2

METHODOLOGY

2.1 Participants

A hundred forty-four (109 female) Boğaziçi University undergraduate students participated in experiment in return for extra course credit. There was no age difference between female ($M=20.27$, $SD= 1.14$) and male ($M= 20.88$, $SD= 2.01$) participants. Data of 12 participants were excluded from analyses since either BDI, TAS or EDE-Q was not filled out or due to absence of adequate number of SDMs.

2.2 Materials

2.2.1 SDM Questionnaire (Singer & Moffitt, 1991)

The questionnaire was adapted from Singer and Moffitt (1991) by Mutlutürk & Tekcan (2015). The participants were asked to write 3 SDMs according to the given instructions (see Appendix A).

2.2.2 Thinking About Life Experiences Scale (TALE-R)

TALE scale was developed by Bluck, Alea, Habermas, and Rubin (2005) and revised by Bluck and Alea (2008) to measure the functions (directive, self, and social) of ABMs. The scale consists of 15 items, each one is rated on 6-point Likert scale (1-almost never to 6-very frequently). Scale was translated to Turkish by the author (see Appendix B).

2.2.3 Toronto Alexithymia Scale (TAS)

This scale was developed by Bagby, Parker, and Taylor (1994) and it is used to measure the extend of emotional dysregulation. The scale consists of 20 items; each one was rated on 5-point Likert scale (1- never to 5 always). TAS was adapted to Turkish by Güleç, Köse, Güleç, Çitak, & Evren et al. (2009) (see Appendix C).

2.2.4 Beck Depression Inventory (BDI).

This inventory was developed by Beck (1961) and used to measure depression level. The inventory consists of 21 items on a 4-point Likert scale. BDI is adapted to Turkish by Hisli (1988) (see Appendix D).

2.2.5 Eating Disorder Examination Questionnaire (EDE-Q)

EDE-Q was developed by Fairburn and Cooper (1994) and used to measure different aspects of dietary restriction. It had four subscales; restraint eating, eating concern, shape concern and weight concern. The questionnaire consisted of 28 items on a 7-point Likert scale. EDE-Q was adapted to Turkish by Yücel, Polat, İkiz, Dugor, Yavuz, and Berk (2011) (see Appendix E).

2.3 Procedure

Participants were asked to retrieve 3 SDMs and fill out TALE-R for each. Then, they were asked to fill out EDE-Q, BDI and TAS in a silent room; there was no time restriction. It took approximately 40 minutes. The experiment was conducted in a classroom in groups of ten.

2.4 Scoring

2.4.1 Specificity (Singer-Blagov, 2000-2001)

Each of the SDMs were coded as specific (Type 1, Type2, and Type 3) or non-specific (Episodic and Generic). Type 1 specific narratives are “pure specific memories”. Type 2 specific narratives are similar to Type 1 but include generalization and background information. Type 3 specific narratives are composed of “multiple single events”. Both episodic and generic narratives lack of specific events and lasts more than a few days. Episodic narratives are composed of more than one non-specific memories. Generic narratives consist of repetitive events (see Appendix F).

2.4.2 Integration (Singer & Blagov, 2000-2001)

Each of the SDMs were coded as integrative (Type 1, Type 2) if the person took any lesson from that event or events, or non-integrative (Type 1, Type 2) in absence of any lesson. Integrative memories may include general knowledge about life or they might be learnt from another person (Type 1). In other cases, they are directly related to self (Type 2). Non-integrative memories either include a specific time frame (Type 1) or they are categorized according to the impact of the memory, elicited emotion, contextual information (Type 2), (see Appendix G).

2.4.3 Content (Thorne & McLean, 2001)

The content of SDMs were coded according to eight categories; *relationship* (family, friend, love, other), *achievement* (success, failure), *life-threatening events* (death or serious injury of someone else, serious/accident illness of self, physical

assault to oneself, physical assault by oneself, rape/sexual abuse to oneself, other), *provocation, risk-taking behaviour guilt/shame, weight and other*. In addition to these eight main content categories, a weight-related category was used.

Furthermore, SDMs were coded according to *people in memories* (individual, family members, friends, love, social, social authority, other, dyadic) and *emotional valence* (positive, negative, neutral). Also SDMs were coded according to *people in memories* and *emotional valence*. Furthermore, for each of the memory *agency* was coded when there was an explicit effect of action or role of the narrator in the course of events. Each of the subcategories was encoded as present (1) or absent (0). Since both the *content* and *people in memories* may include more than one subcategory, a central event and central person categories were encoded for each of them.

CHAPTER 3

RESULTS

3.1 Descriptive Statistics

The main independent variable in this study was the eating attitudes of the participants who were categorized as low and high groups depending on their scores on EDE-Q. We calculated 4 sub-scores (for subscales of *retrained eating*, *eating concern*, *shape concern* and *weight concern*) and a total score for each participant. We divided participants into two groups using interquartile range. Participants with the lowest scores (bottom 25%) fell into low group and participants with highest scores (top 25%) fell into high group. The same methodology was used by constituting groups for subscales and total score of EDE-Q. As a result, a total of ten groups were constituted including high and low ranges of each subscale and a total score. For all participants, characteristics of SDMs, TALEs, BDI, TAS and EDE-Q were analysed.

Table 1. Descriptives for total and subgroups of EDE-Q

		<i>N</i>	<i>BDI</i>	<i>TAS</i>
Total EDE-Q	<i>Low</i>	33	10.41	17.79
	<i>High</i>	33	17.60	18.50
Restrained Eating	<i>Low</i>	41	11.73	18.19
	<i>High</i>	34	14.14	17.81
Eating Concern Group	<i>Low</i>	50	10.44	17.98
	<i>High</i>	36	17.03	18.46
Shape Concern	<i>Low</i>	33	10.89	18.40
	<i>High</i>	35	17.62	17.98
Weight Concern	<i>Low</i>	38	10.77	17.58
	<i>High</i>	38	18.15	18.18

Below, analyses were reported regarding how eating attitudes of participants affected the dependent variables: content, specificity and functions (self, social, and directive) self-defining memories. Depression (BDI) and Alexithymia (TAS) scores were treated as covariate factors for any confounding effect.

For each dependent variable, we used two measures. First we averaged the responses for the three memories each participants recalled. When multiple memories are elicited from the same participant, there is the possibility that characteristics of later memories (content, emotional valence etc.) might be influenced by the first retrieved memory. Therefore, each analysis was carried out on

both for the first memories reported by the participants and the average responses of three SDMs.

3.2 Content

We predicted that retrieval of weight-related content in high EDE-Q group and high subgroups will be higher than that of low EDE-Q group. However, since there was no adequate number of contents for main categories, only the results of total EDE-Q group were reported. Each memory was coded according to main content categories (relationship, achievement, life-threatening events, provocation, risk-taking behaviour guilt/shame, weight and other). Unfortunately, only one of the participants retrieved weight-related content. No significant differences were found between the content of SDMs in low and high EDE-Q groups, $X^2(1) = 2.45, p = .78$. Distribution of central events for 3 SDMs are provided for both high and low EDE-Q groups. Central events for first, second and third SDMs are provided in the Table 1, 2, and 3.

Table 2. Central event of first SDMs in low and high EDE-Q groups

		CENTRAL EVENTS OF FIRST SDMs									
		Relationship	Achievement	Life - threatening event	Provocation	Risk-taking behavior	Guilt / Shame	Weight	Other	Total	
EDE-Q	Low	Count	16	10	3	1	0	0	0	4	34
		% of Total	23.2%	14.5%	4.3%	1.4%	0%	0%	0.0%	5.8%	49.3%
	High	Count	14	8	6	1	0	0	1	5	35
		% of Total	20.3%	11.6%	8.7%	1.4%	0%	0%	1.4%	7.2%	50.7%
	Total	Count	30	18	9	2	0	0	1	9	69
		% of Total	43.5%	26.1%	13.0%	2.8%	0%	0%	1.4%	13.0%	100.0%

Table 3. Central event of second SDMs in low and high EDE-Q groups

		CENTRAL EVENTS OF SECOND SDMs									
		Relationship	Achievement	Life - threatening event	Provocation	Risk-taking behavior	Guilt / Shame	Weight	Other	Total	
EDE-Q	Low	Count	17	8	5	1	1	0	0	2	34
		% of Total	24.6%	11.6%	7.2%	1.4%	1.4%	0%	0%	2.9%	49.3%
	High	Count	24	4	4	0	0	0	0	3	35
		% of Total	34.8%	5.8%	5.8%	0.0%	0.0%	0%	0%	4.3%	50.7%
	Total	Count	41	12	9	1	1	0	0	5	69
		% of Total	59.4%	17.4%	13.0%	1.4%	1.4%	0%	0%	7.2%	100.0%

Table 4. Central event of third SDMs in low and high EDE-Q groups

		CENTRAL EVENTS OF THIRD SDMs									
		Relationship	Achievement	Life - threatening event	Provocation	Risk-taking behavior	Guilt / Shame	Weight	Other	Total	
EDE-Q	Low	Count	16	5	4	1	0	1	0	6	33
		% of Total	24.2%	7.6%	6.1%	1.5%	0.0%	1.5%	0%	9.1%	50.0%
	High	Count	17	4	5	1	1	0	0	5	33
		% of Total	25.8%	6.1%	7.6%	1.5%	1.5%	0.0%	0%	7.6%	50.0%
	Total	Count	33	9	9	2	1	1	0	11	66
		% of Total	50.0%	13.7%	13.7%	3.0%	1.5%	1.5%	0%	16.7%	100.0%

3.3 Specificity

Two separate ANCOVAs were conducted for total EDE-Q score and 4 subgroups to explore the relationship between eating attitudes and specificity of SDMs. High and low groups were constituted using interquartile range as mentioned before. However, in the first analysis, total numbers of specific SDMs of each participant were treated as DV, whereas for the latter only the specificity of first SDMs were treated as DV. In each of the analyses high and low groups were treated as IV, depression (BDI) and alexithymia (TAS) as covariate factors. Total number of specific and non-specific memories of groups are provided in the Table 5.

Table 5. Total number of specific and non-specific self-defining memories for total EDE-Q and sub-groups

		Total number of specific SDMs	Total number of non- specific SDMs	Total %
<i>Total EDE-Q</i>	Low	78 78.8%	21 21.2%	100%
	High	86 86.9%	13 10.1%	100%
<i>Restrained Eating</i>	Low	103 83.7%	20 16.3%	100%
	High	79 77.5%	23 22.5%	100%
<i>Eating Concern</i>	Low	124 82.7%	26 17.3%	100%
	High	92 85.2%	16 14.8%	100%
<i>Shape Concern</i>	Low	79 79.8%	20 20.2%	100%
	High	90 85.7%	15 14.3%	100%
<i>Weight Concern</i>	Low	88 77.2%	26 22.8%	100%
	High	96 84.2%	18 15.8%	100%

3.3.1 Total EDE-Q

Participants were divided into two groups as *low EDE-Q group* ($N = 33$) and *high EDE-Q group* ($N = 33$) using interquartile range. The results demonstrated no main effect for total EDE-Q, $F(1, 62) = 1.32, p = .32, \eta^2 = .02$. Both BDI and TAS also had no significant covariate effects on specificity level (all p 's $< .70$). When we conducted the same analysis for the specificity of first SDMs, the results did not change (all p 's $> .58$).

3.3.2 Restrained Eating

Participants were divided into two groups as *low eating-restrained group* ($N = 41$) and *high eating-restrained group* ($N = 34$) using interquartile range. The results demonstrated no main effect for restrained eating, $F(1, 68) = 1.92, p = .17, \eta^2 = .03$, although BDI had a marginally significant effect $F(1, 68) = 3.62, p = .061, \eta^2 = .05$. TAS had no significant covariate effect on specificity level ($F < 1, p = .59$). When we conducted the same analysis for the specificity of first SDMs, the results did not change (all p 's $> .17$).

3.3.3 Eating Concern

Participants were divided into two groups as *low eating-concern group* ($N = 50$) and *high eating-concern group* ($N = 36$) using interquartile range. The results demonstrated no main effect for restrained eating, $F(1, 80) = 1.22, p = .27, \eta^2 = .02$. Both BDI and TAS also had no significant covariate effects on specificity level (all p 's $> .27$). When we conducted the same analysis with the specificity of first SDMs, the results did not change (all p 's $> .21$).

3.3.4 Shape Concern

Participants were divided into two groups as *low shape-concern group* ($N = 33$) and *high shape-concern group* ($N = 35$) using interquartile range. The results demonstrated no main effect for shape concern, $F(1, 64) = 1.00, p = .32, \eta^2 = .02$. Both BDI and TAS also had no significant covariate effects on specificity level (all p 's $> .21$). When we conducted the same analysis for the specificity of first SDMs, the results did not change (all p 's $> .58$).

3.3.5 Weight Concern

Participants were divided into two groups as *low weight-concern group* ($N = 38$) and *high weight-concern group* ($N = 38$) using interquartile range. The results demonstrated no main effect for weight concern, $F(1, 71) = 1.21, p = .27, \eta^2 = .02$. Both BDI and TAS also had no significant covariate effects on specificity level (all p 's $> .27$). When we conducted the same analysis with the specificity of first SDMs, the results did not change (all p 's $> .44$).

Our results demonstrated that there was no main effect of group on specificity.

Depression had a marginally significant effect for only restrained eating group.

Alexithymia had no effect.

3.4 Integration

Two separate ANCOVAs were conducted for total EDE-Q score and 4 subgroups to explore the relationship between eating attitudes and specificity of SDMs. High and low groups were constituted using interquartile range as mentioned before. However, in the first analysis, total numbers of integrative SDMs of each participant were treated as DV, whereas for the latter only the integration of first SDMs was treated as

DV. In each of the analysis high and low groups were treated as IV, depression (BDI) and alexithymia (TAS) as covariate factors. Total number of integrative and non-integrative memories of groups are provided in the Table 5.

Table 6. Total number of integrative and non-integrative self-defining memories for total EDE-Q and sub-groups

		Total number of integrative SDMs	Total number of non- integrative SDMs	Total %
<i>Total EDE-Q</i>	Low	71 71.7%	28 28.3%	100%
	High	78 78.8%	21 21.2%	100%
<i>Restrained Eating</i>	Low	94 76.4%	29 23.6%	100%
	High	74 72.5%	28 27.5%	100%
<i>Eating Concern</i>	Low	111 74%	39 26%	100%
	High	82 76%	26 24%	100%
<i>Shape Concern</i>	Low	74 74.7%	25 25.3%	100%
	High	80 76.2%	25 23.8%	100%
<i>Weight Concern</i>	Low	77 67.5%	37 32.5%	100%
	High	85 74.6%	29 25.5%	100%

3.4.1 Total EDE-Q

Participants were divided into two groups as *low EDE-Q group* ($N = 33$) and *high EDE-Q group* ($N = 33$) using interquartile range. The results indicated no main effect for total EDE-Q score ($F < 1, p = .93$). Both BDI and TAS also had not significant covariate effects on integration level (both $F < 1$, all p 's $< .76$).

3.4.2 Restrained Eating

Participants were divided into two groups as *low restrained-eating group* ($N = 41$) and *high eating-restrained group* ($N = 34$) using interquartile range. The results demonstrated no main effect for restrained eating, $F(1, 69) = 0.26, p = .61, 1, \eta p^2 < .001$. Both BDI and TAS also had not significant covariate effects on integration level (all p 's $> .46$). When we conducted the same analysis with the integration of first SDMs, the results did not change (all p 's $> .51$).

3.4.3 Eating Concern

Participants were divided into two groups as *low eating-concern group* ($N = 50$) and *high eating-concern group* ($N = 36$) using interquartile range. The results demonstrated no main effect for eating concern ($F < 1$). Both BDI and TAS also had not significant covariate effects on integration level (all p 's $> .88$). When we conducted the same analysis for the integration of first SDMs, the results did not change (all p 's $> .17$).

3.4.4 Shape Concern

Participants were divided into two groups as *low weight-concern group* ($N = 33$) and *high weight-concern group* ($N = 35$) using interquartile range. The results

demonstrated no main effect for shape concern ($F < 1$). Both BDI and TAS also had no significant covariate effects on integration level (all p 's $> .52$). When we conducted the same analysis for the integration of first SDMs, the results did not change (all p 's $> .42$).

3.4.5 Weight Concern

Participants were divided into two groups as *low weight-concern group* ($N = 38$) and *high weight concern group* ($N = 38$) using interquartile range. The results demonstrated no main effect for weight concern ($F < 1$). Both BDI and TAS also had no significant covariate effects on integration level (all p 's $> .93$). When we conducted the same analysis for the integration of first SDMs, the results did not change (all p 's $> .48$).

Our results demonstrated that there was no main effect of group on integration.

Neither depression nor alexithymia had any covariate effects.

3.5 Emotional Valence

Two separate ANCOVAs were conducted for total EDE-Q score and 4 subgroups to find out the relationship between eating attitudes and emotional valence of SDMs. High and low groups were constituted using interquartile range as mentioned before. However in the first analysis, total number of positive, negative and neutral SDMs of each subject were treated as DV, whereas for the latter only the emotional valence of first SDMs were treated as DV. In each of the analysis, high and low groups were treated as IV, depression (BDI) and alexithymia (TAS) as covariate factors (all p 's $> .05$). Total number of positive, negative and neutral number of memories for groups are provided in the Table 7.

Table 7. Total number of positive, negative and neutral self-defining memories for total EDE-Q and sub-groups

		Total number of positive SDMs	Total number of negative SDMs	Total number of neutral SDMs	Total
<i>Total EDE-Q</i>	Low	37 37.4%	38 38.4%	24 24.2%	100%
	High	28 28.3%	49 49.5%	22 22.2%	100%
<i>Restrained Eating</i>	Low	41 33.3%	50 40.7%	32 26%	100%
	High	30 29.4%	47 46.1%	25 24.5%	100%
<i>Eating Concern</i>	Low	59 39.3%	60 40%	31 20.7%	100%
	High	29 26.9%	53 49.1%	26 24%	100%
<i>Shape Concern</i>	Low	33 33.3%	42 42.4%	24 24.3%	100%
	High	36 34.3%	56 53.3%	13 12.4%	100%
<i>Weight Concern</i>	Low	41 36.6%	45 40.2%	26 23.2%	100%
	High	28 25%	65 58%	19 17%	100%

3.5.1 Total EDE-Q

Participants were divided into two groups as *low EDE-Q group* ($N = 33$) and *high EDE-Q group* ($N = 33$) using interquartile range. The results demonstrated no main effect for total EDE-Q, $F(1, 62) = 1.56, p = .22, \eta p^2 = .25$. Both BDI and TAS also had not significant covariate effects on total emotional valence of SDMs (all p 's $> .90$). When we conducted the same analysis with the emotional valence of first SDMs, the results did not change (all p 's $> .51$).

3.5.2 Restrained Eating

Participants were divided into two groups as *low restrained-eating group* ($N = 41$) and *high restrained-eating group* ($N = 34$) using interquartile range. The results demonstrated no main effect for total restrained eating, $F(1, 69) = 1.85, p = .18, \eta p^2 = .26$. Both BDI and TAS also had no significant covariate effects on total emotional valence of SDMs (all p 's $> .52$). When we conducted the same analysis with the emotional valence of first SDMs, the results did not change (all p 's $> .89$).

3.5.3 Eating Concern

Participants were divided into two groups as *low eating-concern group* ($N = 50$) and *high eating-concern group* ($N = 36$) using interquartile range. The results demonstrated no main effect for eating concern, $F(1, 81) = 1.13, p = .29, \eta p^2 = .014$. Both BDI and TAS also had no significant covariate effects on total emotional valence of SDMs (all p 's $> .66$). When we conducted the same analysis with the emotional valence of first SDMs, the results did not change (all p 's $> .50$).

3.5.4 Shape Concern

Participants were divided into two groups as *low shape-concern group* ($N = 33$) and *high shape-concern group* ($N = 35$) using interquartile range. The results demonstrated no main effect for total shape concern, $F < 1$, $p = .33$, $\eta p^2 = .015$. Both BDI and TAS also had no significant covariate effects on total emotional valence of SDMs (all p 's $> .28$). When we conducted the same analysis with the emotional valence of first SDMs, the results did not change (all p 's $> .56$).

3.5.5 Weight Concern

Participants were divided into two groups as *low weight concern group* ($N = 38$) and *high weight concern group* ($N = 38$) using interquartile range. The results demonstrated no main effect for total weight concern, $F < 1$, $p = .62$, $\eta p^2 = .003$. Both BDI and TAS also had no significant covariate effects on total emotional valence of SDMs (all p 's $> .40$). When we conducted the same analysis with the emotional valence of first SDMs, the results did not change (all p 's $> .38$). Our results demonstrated that there was no main effect of group on any emotional valence. Neither depression nor alexithymia had any covariate effects.

3.6 Functions of SDMs

Two separate mixed ANOVAs were conducted for total EDE-Q score and 4 subgroups. High and low groups were constituted using interquartile range as mentioned before. However in the first analyses, average of self, social, and directive function of SDMs of each subject were treated as DV, whereas for the latter, only the self, social, and directive functions of first SDMs were treated as DV. In each of the analysis, high and low groups were treated as IV, self, social, and directive function

scores as DV, depression (BDI) and alexithymia (TAS) as covariate factors. Both the average self, social, and directive function scores of three SDMs and the first memory are provided in the Table 8 and 9.

Table 8. Self, social, and directive function scores of 3 SDMs for total EDE-Q and sub-groups

		Self-function scores		Social-function scores		Directive-function scores	
		<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>
<i>Total EDE-Q</i>	Low	20.52	0.88	16.18	0.87	19.37	0.90
	High	19.37	0.88	16.39	0.87	18.40	0.90
<i>Restrained Eating</i>	Low	20.54	0.66	16.15	0.67	19.38	0.69
	High	20.72	0.72	16.58	0.73	19.06	0.75
<i>Eating Concern</i>	Low	20.52	0.60	16.07	0.65	19.40	0.64
	High	20.44	0.71	16.86	0.77	18.73	0.75
<i>Shape Concern</i>	Low	20.59	0.83	15.23	0.78	19.38	0.82
	High	19.45	0.81	16.51	0.76	18.39	0.79
<i>Weight Concern</i>	Low	20.31	0.73	16.26	0.72	19.16	0.74
	High	20.12	0.73	16.24	0.72	18.65	0.74

Table 9. Self, social and directive function scores of first SDMs for total EDE-Q and sub-groups

		Self-function scores		Social-function scores		Directive-function scores	
		<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>
<i>Total EDE-Q</i>	Low	20.50	0.92	15.68	1.07	20.50	0.99
	High	18.46	0.90	16.14	1.05	17.11	0.98
<i>Restrained Eating</i>	Low	20.32	0.75	15.43	0.91	20.16	0.86
	High	19.94	0.83	15.94	1.00	18.39	0.95
<i>Eating Concern</i>	Low	20.29	0.69	15.56	0.82	20.09	0.81
	High	19.37	0.80	16.13	0.96	16.99	0.96
<i>Shape Concern</i>	Low	20.13	0.91	15.93	0.97	20.01	0.99
	High	18.93	0.88	14.65	1.00	17.34	0.96
<i>Weight Concern</i>	Low	20.25	0.80	15.95	0.94	19.90	0.93
	High	19.02	0.79	15.25	0.93	17.97	0.92

3.6.1 Total EDE-Q

Participants were divided into two groups as *low EDE-Q group* ($N = 33$), and high EDE-Q group ($N = 33$) using interquartile range. A 2 (EDE-Q: high or low) x 3 (average score function types: self, social or directive) mixed ANOVA (where the latter factor was within-subjects) revealed no significant main effect of EDE-Q ($F < 1, p = .57$), and function type ($F < 1, p = .84$). TAS and BDI had also no significant

covariate effects (both $F < 1$, all p 's $> .25$). All the interactions (including function type x TAS, function type x BDI, and function type x EDE-Q) are non-significant (all $F < 1$, all p 's $> .46$).

Another 2 (total EDE-Q group: high or low) x 3 (function types of first SDM: tale self, tale social or tale directive) mixed ANOVA (where the latter factor was within-subjects) also revealed no significant main effect of total EDE-Q score, $F(1, 65) = 1.99$, $p = .16$, $\eta p^2 = 0.03$, and function type of first SDM ($F < 1$, $p = .91$). TAS and BDI had no significant covariate effects (all p 's $> .11$). All the interactions (including function type of first SDM x TAS, function type of first SDM x BDI, and function type of first SDM x EDE-Q) are non-significant (all p 's $> .07$).

3.6.2 Restrained Eating

Participants were divided into two groups as *low restrained-eating group* ($N = 41$) and *high restrained-eating group* ($N = 34$) using interquartile range. A 2 (Restrained eating group: high or low x 3 (average scores of function types: self, social or directive) mixed ANOVA (where the latter factor was within-subjects) revealed no significant main effect of restrained eating ($F < 1$, $p = .69$), and function type, $F(2,142) = 1.36$, $p = .26$, $\eta p^2 = 0.02$. TAS and BDI had no significant covariate effects (all p 's $> .14$). All the interactions (including function type x TAS, function type x BDI, and function type x Restrained Eating) were non-significant (all $F < 1$, all p 's $> .75$).

Another 2 (Restrained eating group: high vs low) x 3 (function type of first SDM: tale self, tale social, and tale directive) mixed ANOVA (where the latter factor was within-subjects) also revealed no significant main effect of restrained eating score ($F < 1$, $p = .80$) and function type of first SDM ($F < 1$, $p = .48$). TAS and BDI

had no significant covariate effects (all p 's $> .16$). All the interactions (including function type of first SDM x TAS, function type of first SDM x BDI and function type of first SDM x Restrained Eating) were non-significant (all p 's $> .25$).

3.6.3 Eating Concern

Participants were divided into two groups as *low eating-concern group* ($N = 50$) and *high eating concern group* ($N = 36$) using interquartile range. A 2 (Eating concern group: high vs low) x 3 (average scores of function types: self, social, and directive) mixed ANOVA (where the latter factor was within-subjects) revealed no significant main effect of eating concern scores ($F < 1$, $p = .82$). However, there was a main effect of function type, $F(2,164) = 4.10$, $p = .02$, $\eta p^2 = 0.05$. Self-function ($M = 20.50$, $SE = .47$) had significantly higher scores than both social ($M = 16.47$, $SE = .50$) and directive function ($M = 19.09$, $SE = .50$). All comparisons were significant at $p < .001$. TAS and BDI had no significant covariate effects (all p 's $> .26$). All the interactions (including function type x TAS, function type x BDI, and function type x eating concern) were non-significant (all p 's $> .29$).

Another 2 (Eating concern group: high vs low) x 3 (function types of first SDM: tale self, tale social, and tale directive) mixed ANOVA (where the latter factor was within-subjects) also revealed no significant main effect of eating concern, $F(1, 86) = 1.51$, $p = .80$, $\eta p^2 = .02$, and function type of first SDM, $F(2, 172) = 1.11$, $p = .33$, $\eta p^2 = .01$. TAS and BDI had no significant covariate effects (all p 's $> .16$). The interaction between function type of first SDM x TAS and function type of first SDM x BDI were non-significant (all p 's $> .24$). However, there were a marginally significant interaction between function type of first SDM and eating concern, $F(2,172) = 2.90$, $p = .058$, $\eta p^2 = .033$. Although there was not an overall effect of

low and high eating-concern groups on function types, there was a significant difference on directive function between low ($M = 20.09$, $SE = 0.81$; 95% CI [18.48, 21.69]) and high ($M = 16.99$, $SE = 0.96$; 95% CI [15.09, 18.89]) eating concern groups. See Figure 1.

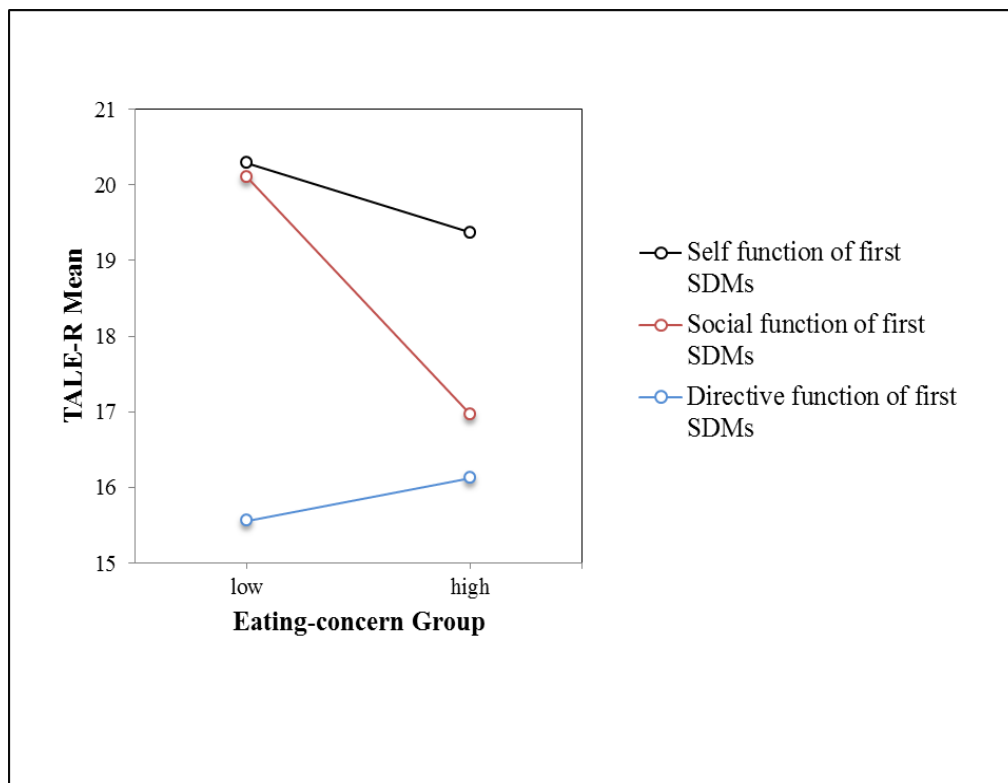


Figure 1. The interaction between eating concern group and function type of first SDMs

3.6.4 Shape Concern

Participants were divided into two groups as *low shape-concern group* ($N = 33$) and *high shape-concern group* ($N = 35$) using interquartile range. A 2 (Shape concern group: high vs low) x 3 (average score function types: self, social, and directive)

mixed ANOVA (where the latter factor was within-subjects) revealed no significant main effect of shape concern ($F < 1$, $p = .78$) and function type, ($F < 1$, $p = .66$). TAS and BDI had also no significant covariate effects (all p 's $> .24$). All the interactions (including function type x TAS, function type x BDI, and function type x shape concern) were non-significant (all $F < 1$, all p 's $> .75$).

The interaction between average score function types x TAS and average score of function types x BDI were not significant (all p 's $> .63$). However, there was a significant interaction between average score of function types and shape concern, $F(2,128) = 3.09$, $p = .049$, $\eta p^2 = .046$. While low shape-concern group had higher average self ($M = 20.59$, $SE = 0.83$; 95% CI [18.92, 22.26]) and directive function ($M = 19.38$, $SE = 0.82$; 95% CI [17.74, 21.01]) scores than high shape-concern group ($M = 19.45$, $SE = 0.81$; 95% CI [17.83, 21.06]; ($M = 18.39$, $SE = 0.79$; 95% CI [16.80, 19.97] *respectively*), there was a reverse pattern for average social function scores. High shape-concern group ($M = 16.51$, $SE = 0.76$; 95% CI [15.0, 18.02]) had higher average social function scores than low shape-concern group ($M = 15.23$, $SE = 0.78$; 95% CI [13.67, 16.79]). See Figure 2.

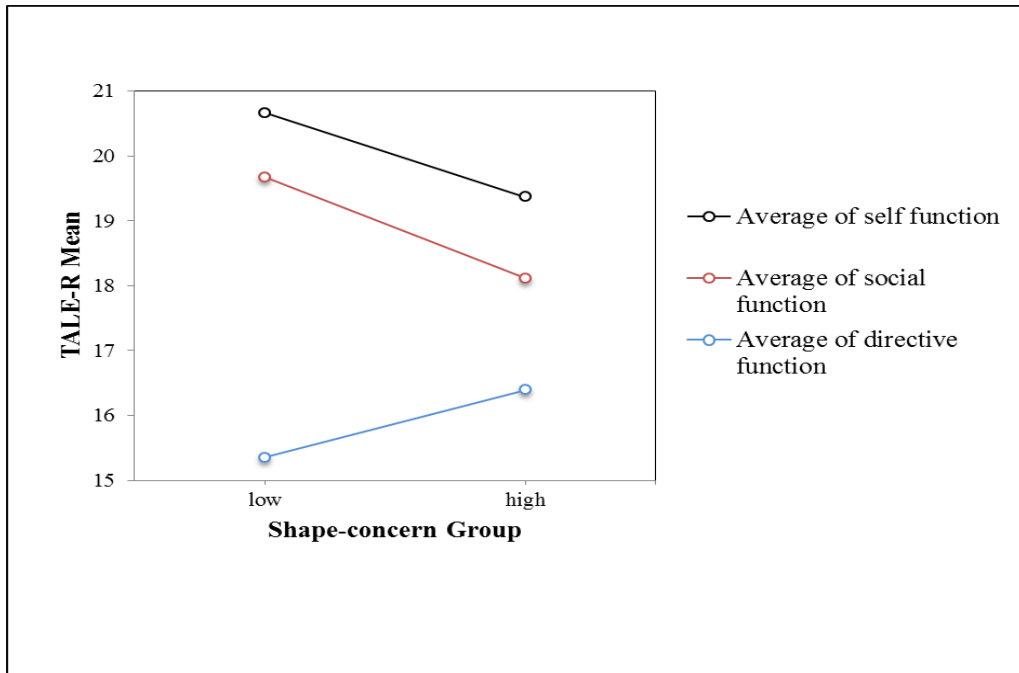


Figure 2. The interaction between shape concern group and function type of average scores

Another 2 (Shape concern group: high vs low) x 3 (function types of first SDM: tale self, tale social, and tale directive) mixed ANOVA (where the latter factor was within-subjects) also revealed no significant main effect of shape concern, $F < 1$, $p = .43$, and function type of first SDM, $F < 1$, $p = .99$. TAS and BDI had also no significant covariate effects (all p 's $> .18$). The interaction between function type of first SDM x TAS and function type of first SDM x BDI were not significant (all p 's $> .36$). However, there was a significant interaction between function type of first SDM and shape concern scores, $F(2,136) = 3.44$, $p = .035$, $\eta p^2 = .048$.

While low shape-concern group had higher average self ($M = 20.13$, $SE = 0.91$; 95% CI [18.32, 21.94]) and directive function ($M = 20.01$, $SE = 0.99$; 95% CI [18.03, 22.0]) scores than high shape-concern group ($M = 18.93$, $SE = 0.88$; 95% CI [17.18, 20.69]; ($M = 17.34$, $SE = 0.96$; 95% CI [15.41, 19.26] respectively), there was a reverse pattern for average social function scores. High shape-concern group ($M = 15.93$, $SE = 0.97$; 95% CI [13.98, 17.87]) had higher average social function

scores than low shape-concern ($M = 14.65$, $SE = 1.00$; 95% CI [12.64, 16.65]. See Figure 3.

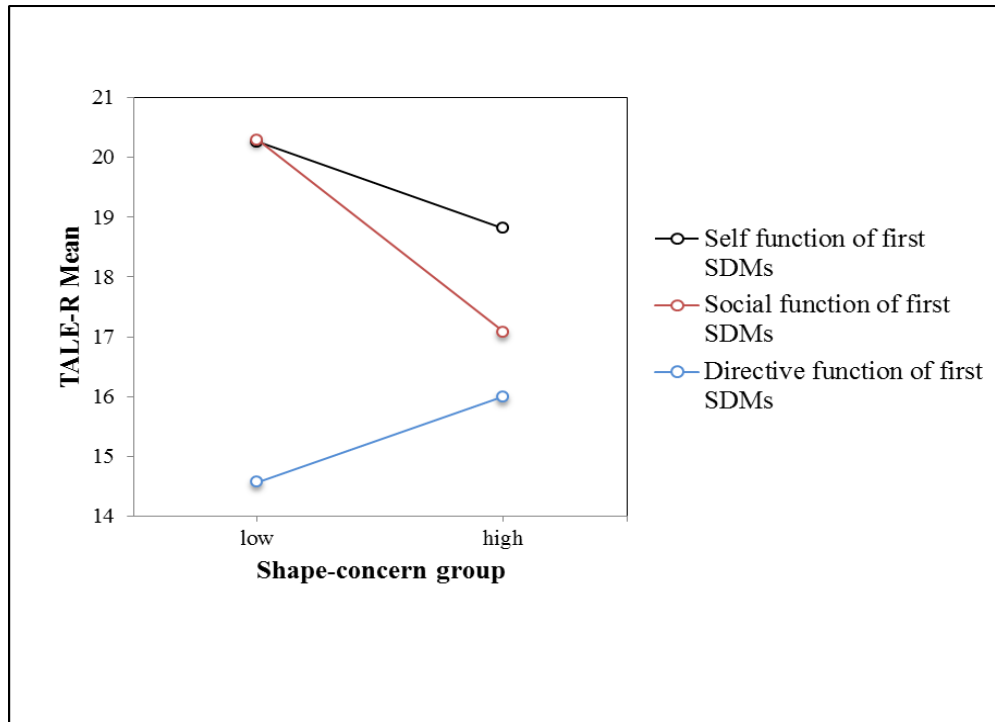


Figure 3. The interaction between shape concern group and function type of first SDMs

3.6.5 Weight Concern

Participants were divided into two groups as *low weight-concern group* ($N = 38$) and *high weight-concern group* ($N = 38$) using interquartile range. A 2 (Weight concern group: high vs low) x 3 (average score function types: self, social, and directive) mixed ANOVA (where the latter factor was within-subjects) revealed no significant main effect of weight concern ($F < 1$, $p = .91$), and function type, ($F < 1$, $p = .87$). TAS and BDI had also no significant covariate effects (all p 's $> .35$). All the interactions (including function types x TAS, function types x BDI, and function types x weight concern) were non-significant (all p 's $> .21$).

Another 2 (Weight concern group: high vs low x 3 (function type of first SDM: tale self, tale social, and tale directive) mixed ANOVA (where the latter factor was within-subjects) also revealed no significant main effect of weight concern ($F < 1, p = .80$) and function type of first SDM ($F < 1, p = .48$). TAS and BDI had also no significant covariate effects (all p 's $> .16$). All the interactions (including function types of first SDM x TAS, function types of first SDM x BDI, and functions types of first SDM x Weight Concern were non-significant (all p 's $> .25$).

To sum up the results for functions of SDMs, low eating-concern group had higher scores for directive function than those for high eating group. The other finding was low shape-concern group had higher average self and directive function scores than those of high group. A reverse pattern was observed for average social function scores; high shape-concern group had higher social function scores for both average and first SDMs. Second significant difference within shape-concern groups was found for their social function scores; high shape-concern group had higher social function scores than those for low shape-concern group.

CHAPTER 4

DISCUSSION

The main goal of the present paper was to investigate characteristics (content, specificity, integration, and emotional valence) and functions (self, social, and directive) of self-defining memories (SDMs) in restrained eaters. To our knowledge, this is the first empirical study to address self-defining memories and their various characteristics in individuals with abnormal eating attitudes. Moreover, although several studies looked at SDMs with different clinical diagnoses such as depression and schizophrenia (e.g. Moffitt et al., 1994, Berna et al. 2011), the present study is the first to address functions of SDMs.

We categorized the participants into low- and high groups in terms of the total EDE-Q scores as well as their scores on each individual subscale measuring restrained eating, shape concerns, weight concerns, and eating concerns. Results showed no main effect of group on any of the SDM characteristics. In other words, people who were high vs. low on the total EDE-Q as well as the four subscale scores were not different from each other in content, specificity, and integration of the memories. There are two possibilities with regard to why there were null effects. One is that we did not have enough power to detect differences. The other possibility is that there was really no effect between the groups in terms of these memory characteristics. Given that in all cases, the effect size, measured by partial eta squared, was very small, indicating that there was no evidence of a difference between the groups.

The only effects we obtained were about the function of the SDMs. Low eating-concern group had higher scores for directive function than the high eating

group. The other finding was low shape-concern group had higher average self and directive function scores than high group. A reverse pattern was observed for average social function scores; high shape-concern group had higher social function scores for both average and first SDMs. Second significant difference within shape-concern groups was found for their social function scores; high shape-concern group had higher social function scores than low shape-concern group.

4.1 Specificity and Integration

We have predicted that depression would affect the specificity of SDMs; participants whose score are high on BDI would retrieve more over-general memories. There is a large body of literature on this subject and several studies show that depressed people tend to retrieve more over-general ABMs (e.g., Williams & Broadbent, 1986; Williams & Scott, 1988; Kuyken & Dalgliesh, 1995; Wessel, Meeren, Peeter, Arntz, & Merckelbach, 2001). Reduced specificity level predicts depression (e.g., Kleim & Ehlers, 2008). The same tendency is observed for other clinical populations such as schizophrenia (e.g. Berna et al., 2011), PTSD (e.g. Jobson et al., 2008), and borderline personality disorder (Jorgensen et al., 2012). As we mentioned in the introduction these patients retrieve over general self-defining memories. Then, how can we explain our contradictory results?

First, self-defining memories are specific and intrinsically related to self (e.g., Singer et al., 2007; Moffitt et al., 1994). Secondly, specificity is correlated with duration of illness rather than depression or alexithymia in eating disorders such as AN (e.g., Bomba et al., 2011).

Although it is not one of our main hypothesis, integration of SDMs are analyzed and no significant difference was found between groups. In the literature, it

was demonstrated that people with autism spectrum (Crane, Goddard, & Pring, 2009), schizophrenia (Raffard et al., 2009) and repressive-prone retrieve less integrative memories than control groups. This is considered as a result of their emotional dysregulation (Lardi et al., 2012), self-disturbance (Raffard et al., 2009) or inability to update self-concept in light of memories (Crane et al., 2009). Such impairments are too severe to be detectable in a subclinical group, such as the one used in this study.

4.2 Content and Emotional Valence

We also investigated content and emotional valence of SDMs. The results demonstrated no main effect of groups on these memory characteristics. We have predicted that participants who fell into high eating attitude groups would retrieve more weight-related memories. Unexpectedly only one of the participants retrieved a weight-related memory. This result is probably a disadvantage of studying with an analogue group rather than a clinical sample.

Secondly, we hypothesized that people who score high on Alexithymia (TAS) would retrieve more neutral memories. In general, all our groups retrieved less neutral memories compared to positive and negative memories. Since in our instructions we explicitly asked them to retrieve a memory, which elicits positive or negative emotion, this is an expected result. Furthermore, none of the groups scored high on TAS. Also, SDMs have an emotionally intense structure (Singer et al., 2007). This may be the reason why we failed to find significant differences between groups.

4.3 Functions of SDMs

As we mentioned before the only significant differences we observed were about the function (self, social, and directive) of the SDMs. First, we found that low eating-concern group had higher scores for directive function than the high eating-concern group. In other words, low eating-concern group use their SDMs to remember useful experiences to guide their future behavior and to solve their current problems in the light of previous experience (e.g., McCabe et al., 1991, Bluck, 2003). Although there is no study directly investigating the directive function of SDMs in eating disorder patients, it is well known that problem solving and future thinking is an indispensable part of directive function (Pillemer, 2002). Studies revealed that ED patients are not as skillful as healthy group at problem solving.

For example, Holt and Espelage (2002) selected a subclinical ED group similar to ours and showed that they had difficulty finding a solution for especially relationship-oriented problems, and depression was not a predictor for problem-solving skills in subclinical ED group.

The other finding was low shape-concern group had higher average self and directive function than high group, we observed a reverse pattern for average social function scores; high shape-concern group had higher social function scores for both average and first SDMs. As indicated with this result, a memory does not have to serve only a specific function, we may remember a memory both for its directive and social functions. Low shape-concern group use their memories both to plan their future as we have mentioned and for their self-function which helps them to maintain a continuity about who they are more than high shape-concern group. Difference in directive function scores between groups can be explained similar to eating-concern group as we mentioned above. Additionally, the difference between self-functions of

SDMs between low and high shape-concern group was an expected result due to their potential self-impairment; limited and negative self-schemas (Stein et al., 2008). Although identity-impairment model is established for eating disorder patients, we may argue that it is possible to expect at least a predisposition to develop ED for our shape-concern group. Although there may be a specific relationship between body shape perception and self, we still do not know why we did not observe this effect in other groups. Liao, Bluck, Alea and Cheng (2015) demonstrated that people whose self-concept is less stable tend to use self-function of memories more than others to compensate their impaired self-concept regardless of the culture. Although we did not directly measure self-concept of participants, absence of difference for self-function between low and high groups may be explained in this way. The self-function of SDMs should already be high for healthy participants. Individuals with abnormal eating attitudes might have used the self function of SDMs intensively to compensate their impaired self.

The second significant difference within shape-concern groups was found for their social function scores; high shape-concern group had higher social function scores than low shape-concern group. Before considering the reason underlying this result, we should note that this was an unexpected pattern. How could people who concern more about their body shape use their SDMs to maintain more intimate relationships? Holt et al. (2002) demonstrated that perceived social support of subclinical group from family and friend is similar to healthy participants. The reverse pattern in results can be explained in another way. Participants in high shape-concern group may need social support more to overcome their problematic body shape perception.

4.4 Limitations and Suggestions for Future Studies

It should be noted that our participants were not individuals diagnosed with any EDs. Rather; they were analogue groups, categorized into low vs high groups on several aspects of eating/appearance psychopathology.

Therefore, it is possible that the differences observed between these groups might (have been) be larger if we employed a clinical sample. Lastly, specificity and integration of memories might also be affected by the instructions given during memory collection.

Future investigations with a clinical sample or with subclinical groups employing larger sample sizes will elucidate how eating attitudes may alter the functions and characteristics of SDMs. As our most significant results were obtained from a shape-concern group, the specific relationship between body perception of eating disorder and self needs to be explored further.

APPENDIX A

INSTRUCTION FOR SELF-DEFINING MEMORY

Sizden kendinizi tanımlayan, benliğinizi (kim olduğunuzu) yansıtan üç anı hatırlamanızı her birinin ardından da ilişikteki anketi doldurmanızı istiyoruz. Bu anılar aşağıdaki özelliklere sahip olmalıdır:

- Net bir biçimde hatırladığınız
- Hala önemli bulduğunuz
- Sizde olumlu, olumsuz ya da her iki türden de yoğun duygular uyandıran
- Hayatınızda süregelen bir tema, olay ya da çözülmemiş bir meseleyi içeren
- Sizin bir birey olarak kim olduğunuzu tanımlayan ve sizi yakından tanımasını istediğiniz birine anlatmak isteyebileceğiniz
- Sık sık hatırladığınız
- Benzer bir temayı ya da meseleyi içeren başka anılarla bağlantılı ve onları çağrıştıran

Özetlemek gerekirse, bu anılar, yeni tanıştığınız ve kendinizi olduğunuz gibi ve doğru bir şekilde tanıtmak istediğiniz birine anlatabileceğiniz türden, sizin şu andaki siz olmanızda katkısı olmuş anılardır. Lütfen bu tanıma uygun ve 1 seneden eski üç anınızı mümkün olduğunca ayrıntılı biçimde yazınız.

Herhangi bir sorunuz varsa şu anda sorabilirsiniz. Sorunuz yoksa, lütfen deneye başlayınız başlayınız.

APPENDIX B

THINKING ABOUT LIFE EXPERIENCES SCALE - REVISED

Bu anıyı...

Geçmişteki ile aynı insan olduğumu hissetmek istediğimde anımsarım.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>
<i>Asla</i>	<i>Nadiren</i>	<i>Bazen</i>	<i>Genellikle</i>	<i>Sık</i>	<i>Çok sık</i>

Bir başkasının söylemiş ya da yapmış olduğu ve bana şimdi yardımcı olacak bir şeyi hatırlamak istediğimde anımsarım.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>
<i>Asla</i>	<i>Nadiren</i>	<i>Bazen</i>	<i>Genellikle</i>	<i>Sık</i>	<i>Çok sık</i>

Başka bir kişinin nasıl birisi olduğunu anlamak istediğim zaman anımsarım.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>
<i>Asla</i>	<i>Nadiren</i>	<i>Bazen</i>	<i>Genellikle</i>	<i>Sık</i>	<i>Çok sık</i>

Önceden olduğum gibi bir insan olup olmadığım konusunda meraklandığım zaman anımsarım.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>
<i>Asla</i>	<i>Nadiren</i>	<i>Bazen</i>	<i>Genellikle</i>	<i>Sık</i>	<i>Çok sık</i>

Geçmişimle ilgili düşünmenin geleceğime ışık tutmada yardımcı olacağına inandığım zaman anımsarım

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>
<i>Asla</i>	<i>Nadiren</i>	<i>Bazen</i>	<i>Genellikle</i>	<i>Sık</i>	<i>Çok sık</i>

Değer yargılarımın zamanla değişip değişmediğini düşündüğüm zaman anımsarım.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>
<i>Asla</i>	<i>Nadiren</i>	<i>Bazen</i>	<i>Genellikle</i>	<i>Sık</i>	<i>Çok sık</i>

Geçmişteki hatalarımdan ders çıkarmak istediğim zaman anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Bir ilişkimdeki samimiyeti arttırmak istediğim zaman anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Yaşamıma dair bir seçim yapmam gerektiği ve hangi alternatifi seçeceğim konusunda kararsız olduğum zaman anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Geçmişte çıkardığım bir dersi hatırlamak için anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Birisiyle daha samimi bir ilişki geliştirmek istediğim zaman anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Bir arkadaşlığı anılar paylaşarak sürdürmek istediğim zaman anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Düşüncelerimin zaman içerisinde değişip değişmediği konusunda düşündüğüm zaman anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Başka birinin hayatı hakkında daha fazla şey bilmek istediğim zaman anımsarım.

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

Geçmişten bugüne nasıl değiştiğimi anlamak istediğim zaman anımsarım

1 2 3 4 5 6
Asla Nadiren Bazen Genellikle Sık Çok sık

APPENDIX C

TÜRKÇE TORONTO ALEKSİTİMİ ÖLÇEĞİ (TAÖ-20)

	Hiçbir zaman	Nadiren	Bazen	Sık sık	Her zaman
1. Ne hissettiğimi çoğu kez tam olarak bilemem.	1	2	3	4	5
2. Duygularım için uygun kelimeleri bulmak benim için zordur.	1	2	3	4	5
3. Bedenimde doktorların bile anlamadığı duygular oluyor.	1	2	3	4	5
4. Duygularımı kolayca tanımlayabilirim.	1	2	3	4	5
5. Sorunları yalnızca tanımlamaktansa onları çözümlmeyi yeğlerim.	1	2	3	4	5
6. Keyfim kaçtığında, üzgün mü, korkmuş mu yoksa kızgın mı olduğumu bilemem.	1	2	3	4	5
7. Bedenimdeki duygular çoğu kez kafamı karıştırır.	1	2	3	4	5
8. Neden öyle sonuçlandığını anlamaya çalışmaksızın, işleri olurluna bırakmayı yeğlerim	1	2	3	4	5
9. Tam olarak tanımlayamadığım duygularım var.	1	2	3	4	5
10. İnsanların duygularını tanıması zorludur.	1	2	3	4	5
11. İnsanlar hakkında ne hissettiğimi tanımlamak benim için zordur.	1	2	3	4	5
12. İnsanlar duygularım hakkında daha çok konuşmamı isterler.	1	2	3	4	5
13. İçimde ne olup bittiğini bilmiyorum.	1	2	3	4	5
14. Çoğu zaman neden öfkeli olduğumu bilmem.	1	2	3	4	5
15. İnsanlarla, duygularından çok günlük uğraşları hakkında konuşmayı yeğlerim.	1	2	3	4	5
16. Psikolojik dramalar yerine eğlence programları izlemeyi yeğlerim.	1	2	3	4	5
17. İçimdeki duyguları yakın arkadaşlarıma bile açıklamak bana zor gelir.	1	2	3	4	5
18. Sessizlik anlarında bile kendimi birisine yakın hissedebilirim.	1	2	3	4	5
19. Kişisel sorunlarımı çözerken duygularımı incelemeyi yararlı bulurum.	1	2	3	4	5
20. Film ya da tiyatro oyunlarında gizli anlamlar aramak, onlardan alınacak hazzı azaltır.	1	2	3	4	5

APPENDIX D

BECK DEPRESYON ENVANTERİ

1 (0) Üzgün ve sıkıntılı değilim.

- (1) Kendimi üzüntülü ve sıkıntılı hissediyorum.
- (2) Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
- (3) O kadar üzgün ve sıkıntılıyım ki, artık dayanamıyorum.

2 (0) Gelecek hakkında umutsuz ve karamsar değilim.

- (1) Gelecek için karamsarım.
- (2) Gelecekte beklediğim hiçbir şey yok.
- (3) Gelecek hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.

3 (0) Kendimi başarısız biri olarak görmüyorum.

- (1) Başkalarından daha başarısız olduğumu hissediyorum.
- (2) Geçmişe baktığımda başarısızlıklarla dolu olduğunu görüyorum.
- (3) Kendimi tümüyle başarısız bir insan olarak görüyorum.

4 (0) Her şeyden eskisi kadar zevk alıyorum.

- (1) Birçok şeyden eskiden olduğu gibi zevk alamıyorum.
- (2) Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
- (3) Her şeyden sıkılıyorum.

5 (0) Kendimi herhangi bir biçimde suçlu hissetmiyorum.

- (1) Kendimi zaman zaman suçlu hissediyorum.
- (2) Çoğu zaman kendimi suçlu hissediyorum.
- (3) Kendimi her zaman suçlu hissediyorum.

6 (0) Kendimden memnunum.

- (1) Kendimden pek memnun değilim.
- (2) Kendime kızgınım.
- (3) Kendimden nefrete ediyorum.

7 (0) Başkalarından daha kötü olduğumu sanmıyorum.

- (1) Hatalarım ve zayıf taraflarım olduğunu düşünmüyorum.
- (2) Hatalarımdan dolayı kendimden utanıyorum.
- (3) Her şeyi yanlış yapıyor muyum gibi geliyor ve hep kendimde kabahat buluyorum.

8 (0) Kendimi öldürmek gibi düşüncülerim yok.

- (1) Kimi zaman kendimi öldürmeyi düşündüğüm oluyor ama yapmıyorum.
- (2) Kendimi öldürmek isterdim.
- (3) Fırsatını bulsam kendimi öldürürüm.

9 (0) İçimden ağlamak geldiği pek olmuyor.

- (1) Zaman zaman içimden ağlamak geliyor.
- (2) Çoğu zaman ağlıyorum.
- (3) Eskiden ağlayabilirdim ama şimdi istesem de ağlayamıyorum.

10 (0) Her zaman olduğumdan daha canı sıkkın ve sinirli değilim.
(1) Eskisine oranla daha kolay canım sıkılıyor ve kızıyorum.
(2) Her şey canımı sıkıyor ve kendimi hep sinirli hissediyorum.
(3) Canımı sıkkan şeylere bile artık kızamıyorum.

11 (0) Başkalarıyla görüşme, konuşma isteğimi kaybetmedim.
(1) Eskisi kadar insanlarla birlikte olmak istemiyorum.
(2) Birileriyle görüşüp konuşmak hiç içimden gelmiyor.
(3) Artık çevremde hiç kimseyi istemiyorum.

12 (0) Karar verirken eskisinden fazla güçlük çekmiyorum.
(1) Eskiden olduğu kadar kolay karar veremiyorum.
(2) Eskkiye kıyasla karar vermekte çok güçlük çekiyorum.
(3) Artık hiçbir konuda karar veremiyorum.

13 (0) Her zamankinden farklı görüdüğümü sanmıyorum.
(1) Aynada kendime her zamankinden kötü görünüyorum.
(2) Aynaya baktığımda kendimi yaşlanmış ve çirkinleşmiş buluyorum.
(3) Kendimi çok çirkin buluyorum.

14 (0) Eskisi kadar iyi iş güç yapabiliyorum.
(1) Her zaman yaptığım işler şimdi gözümde büyüyor.
(2) Ufacık bir işi bile kendimi çok zorlayarak yapabiliyorum.
(3) Artık hiçbir iş yapamıyorum.

15 (0) Uykum her zamanki gibi.
(1) Eskisi gibi uyuyamıyorum.
(2) Her zamankinden 1-2 saat önce uyanıyorum ve kolay kolay tekrar uykuya dalamıyorum.
(3) Sabahları çok erken uyanıyorum ve bir daha uyuyamıyorum.

16 (0) Kendimi her zamankinden yorgun hissetmiyorum.
(1) Eskkiye oranla daha çabuk yoruluyorum.
(2) Her şey beni yoruyor.
(3) Kendimi hiçbir şey yapamayacak kadar yorgun ve bitkin hissediyorum.

17 (0) İştahım her zamanki gibi.
(1) Eskisinden daha iştahsızım.
(2) İştahım çok azaldı.
(3) Hiçbir şey yiyemiyorum.

18 (0) Son zamanlarda zayıflamadım.
(1) Zayıflamaya çalışmadığım halde en az 2 Kg verdim.
(2) Zayıflamaya çalışmadığım halde en az 4 Kg verdim.
(3) Zayıflamaya çalışmadığım halde en az 6 Kg verdim.

19 (0) Saęlıęımla ilgili kaygılarım yok.

(1) Ağrılar, mide sancıları, kabızlık gibi Őikayetlerim oluyor ve bunlar beni tasalandırıyor.

(2) Saęlıęımın bozulmasından çok kaygılanıyorum ve kafamı başka Őeylere vermekte zorlanıyorum.

(3) Saęlık durumum kafama o kadar takılıyor ki, başka hiçbir Őey dūŐünemiyorum.

20 (0) Sekse karŐı ilgimde herhangi bir deęiŐiklik yok.

(1) Eskisine oranla sekse ilgim az.

(2) Cinsel isteęim çok azaldı.

(3) Hiç cinsel istek duymuyorum.

21 (0) Cezalandırılması gereken Őeyler yapıęımı sanmıyorum.

(1) Yaptıklarımın dolaylı cezalandırılabilceęimi dūŐünüyorum.

(2) Cezamı çekmeyi bekliyorum.

(3) Sanki cezamı bulmuŐum gibi geliyor.

APPENDIX E

YEME BOZUKLUĞU DEĞERLENDİRME ÖLÇEĞİ (YEDÖ)

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

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

	Son 28 günün kaçında...	Hiçbirin- de	1-5 gün	6-12 gün	13-15 gün	16-22 gün	23-27 gün	Her gün
8-	<u>Bedeninizin şekli ve kiloyla ilgili düşünmenin, ilgilendiğiniz konulara (örn. İşinize, bir konuşmayı takip etmenize ya da okumanıza) yoğunlaşmanızı çok zorlaştırdığı oldu?</u>	0	1	2	3	4	5	6
9-	Yemek yemeyle ilgili kontrolü kaybetmekten belirgin biçimde korktuğunuz oldu?	0	1	2	3	4	5	6
10-	Kilo alabileceğinizden belirgin bir biçimde korktunuz?	0	1	2	3	4	5	6
11-	Kendinizi şişman hissettiniz?	0	1	2	3	4	5	6
12-	Kilo vermek için güçlü bir arzunuz oldu?	0	1	2	3	4	5	6

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

19-	Son 28 gün içinde, kaç kere gizlice (örn. Saklanarak) yemek yediniz? (Tıkınırcasına yeme durumlarını saymayınız.)	Hiçbirinde	1 -5 gün	6 -12 gün	13 -15 gün	16 -22 gün	23 -27 gün	Hergün
		0	1	2	3	4	5	6
20-	Yemek yediğiniz zaman bedeninizin şeklini ya da kilonuzu etkilediği için ne oranda kendinizi suçlu hissettiniz (hata yaptığınızı hissettiniz)? (Tıkınırcasına yemek yeme durumlarını saymayınız.)	Hiçbir zaman	Nadiren	Yarıdan az	Yarı yarıya	Yarıdan fazla	Çoğu zaman	Her zaman
		0	1	2	3	4	5	6
21-	Son 28 gün içinde, başkalarının sizi yemek yerken görmesiyle ilgili ne kadar endişelendiniz? (Tıkınırcasına yeme durumlarını saymayınız.)	Hiç		Biraz		Orta		Önemli
		0	1	2	3	4	5	6
		Hiç		Biraz		Orta		Önemli
22-	<u>Kilonuz</u> , kişi olarak kendiniz hakkında düşüncenizi ve yargınızı etkiledi mi?	0	1	2	3	4	5	6
23-	<u>Bedeninizin şekli</u> , kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi mi?	0	1	2	3	4	5	6
24-	Önümüzdeki dört hafta boyunca, haftada 1 kez tartılmanız istense (ne daha sık ne daha seyrek), bu sizi ne kadar üzerdi ?	0	1	2	3	4	5	6
25-	<u>Kilonuzdan</u> ne derece memnun değilsiniz ?	0	1	2	3	4	5	6
26-	<u>Bedeninizin şeklinden</u> ne derece memnun değilsiniz?	0	1	2	3	4	5	6
27-	Bedeninizi görmekten ne kadar rahatsız oluyorsunuz (örn. Aynada, mağazanın camında, soyunurken, banyo ya da duş yaparken)?	0	1	2	3	4	5	6
28-	<u>Başkalarının</u> bedeninizin şeklini görmesinden ne derece rahatsız oluyorsunuz? (örn. Soyunma odalarında, yüzerken ya da dar elbiseler giyerken)	0	1	2	3	4	5	6

Ŗu andaki kilonuz nedir? (Lütfen en yakın tahmini yapınız)

Boyunuz ne kadar? (Lütfen en yakın tahmini yapınız)

Kadınlara : Geçtiđimiz üç-dört aylık dönemde hiç aybaşı (regl) olmadıđınız oldu mu?

Aksama olduysa kaç tane?

Bu nedenle ilaç kullanıyor musunuz?

APPENDIX F

EXAMPLES OF SPECIFIC AND NON-SPECIFIC MEMORIES

Specific Memory

Dershaneden eve yürüyerek dönerken yol kenarında ağır ağır ilerleyen bir bisikletli gördüm. Gidonun önüne yıpranmış Norveç bayrağını bir dal parçası ile asmamış olsaydı dikkatimi çekmezdi belki. Hava soğuktu ve üşüyordu üstelik hasta da olmuştu. Bana ülkesinden fotoğraflar gösterdi. Subaymış oradaki evinde antika eşya koleksiyonu varmış. Betonlaşan dünyadan sıkılıp kendini yollara vurmuş. Türkiye'den geçerek İran'a gidecekti. Norveç'ten çıkan adamla yollarımız Malatya'da keşişmişti. Üzerimde hiç para yoktu, olsaydı son kuruşuna kadar ona verirdim. Norveç'li adamla yol kenarına oturup hayattan bahsettik. Bana Amerikalıların burnu havada insanlar olduğunu söyledi. Hedefin Amerika'ya gitmek olmasın dedi, başarmak olsun.

Non-specific Memory

Lisede okuldaki bir çocukla tanışıp çok yakın arkadaş olduk. Her gün konuşup, her şeyimizi paylaşırdık. Herkes bizi sevgili sanıyordu fakat ne olduğumuz önemli değildi, önemli olan bizim yakınlığımızdı. Bir süre sonra dedikodular beni yıpratmaya başladı ve aramıza bir soğukluk girdi. Normalde bunu anlayıp düzeltmek için her şeyi yapacağımı bildiğim insansa bunun üzerine hiç gitmedi. Yeni arkadaşlar da edinip okulda onlarla zaman geçirmeye başladı. Hayatımın son 1 senesinde her an yanımda olan o kişiyi başkalarıyla daha çok zaman geçirirken görmek beni ondan iyice soğuttu. Okul bittiğinde yaptıklarından dolayı pişman olmuştu ama çok geçti, ben bir kere soğuduğumda geriye dönmem çok zordu. Böylece arkadaşlığımız da tükendi. Ama sonrasındaki davranışları bana iyi ki bittiğini gösterdi. Bir şeyi elde edemeyince mağdurlaşan, üzerine özür diletirip bu özrü egoistçe yanıtlayıp kabul etmeyen bir insan olduğuna ancak bu aşamada şahit oldum.

APPENDIX G

EXAMPLES OF INTEGRATIVE AND NON-INTEGRATIVE MEMORIES

Integrative Memory

Okula yeni başladığım yıld. Yedi yaşındaydım yani. Bi arkadaşımında bisiklet görmüştüm ve bende de olsun istemiştım. Anne babama aşırı derecede ısrar ederek bir bisiklet aldırđım. Babam bir gece işten geldiğinde beraberinde bisikleti de getirdi. Ben o gün çok mutlu ve heyecanlıydım. Hatta heyecanımdan akşam yemeğini bile yiyemedim. Sabah olunca bisikleti sürmek istedim. Bisiklet benim boyuma göre çok az büyükçeydi ve iki tekerlekliydi. Annem daha önce hiç bisiklet sürmediğim gerekçesiyle bu iki tekerlekli bisikleti süremeyeceğimi düşünüyordu ve babama bunun yerine dört tekerlekli bi şey almasını söyledi. Babamsa bana daha fazla güveniyordu. Neyse bisiklete bindim hiç sıkıntı olmadan sürdüm. Hatta zinciri atınca da kendi başıma yaptım. Bundan sonraki motosiklet, araba gibi araçları da kimsenin yardımı olmadan kullanabildim. Bu anımla birlikte ulaştığım birkaç sonuç var. Birincisi annemin şefkatinden olsa gerek bana az güvenmesi. Babamınsa bana tam bir güven içinde olması. İkincisi başkalarından yardım almadan da bir çok şeyi kendi başıma yapabileceğim.

Non-Integrative Memory

6 yaşımıdayken babam fabrikada üç metreden düşüp kolunu kırmıştı. Bu yüzden hastanede yatıyordu. Ses tellerinden de ameliyat olması gerekmişti. Annem de çalışmak zorunda olduğundan ben babaannem ve dedemdeydim bütün gün. Kuzenim yine bizdeydi. Anneme hediye almayı planlamıştık. Mahalledeki marketten renkli renkli yapma çiçeklerden almıştık. Sonra onları bir yerde sakladık. Akşam annem eve geldiğinde çok sinirliydi. Önceki gün yıkadığı halı, balkondan düşerek tekrar kirlenmişti. Sanırım tekrar yıkaması gerekiyordu akşam olduğu halde. Biz kuzenimle çok çekindik annemin bize de kızmasından ve çiçeklere para verdiğimiz için sinirlenmesinden. O yüzden vermedik ona aldığımız halde. Ertesi öğlen babam hastaneden dönünce çiçekleri sanki ona almışız gibi davrandık. Anneme de bundan hiç bahsetmedik. Anneme olayın doğrusunu anlattığımda liseye geçmişti.

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