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RESEARCH ARTICLE

The Predictive Role of Emotion Regulation in the Relationship Between Childhood Traumatic Experiences and Emotional Eating

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ABSTRACT

Background: We aimed to investigate whether emotional regulation mediated potential psychological processes linking emotional eating and different types of childhood maltreatment subtypes.

Methods: A total of 250 individuals aged between 16 and 68 were included in the study between October 1, 2023, and November 1, 2023. A personal data form prepared by the researchers, along with the Childhood Trauma Questionnaire, the Difficulties in Emotion Regulation Scale (DERS-36), and the Emotional Eating Scale were obtained from the individuals.

Results: A strong positive correlation was found between Childhood Maltreatment Experiences and Emotional Eating. A strong positive correlation was found between Childhood Maltreatment Experiences and Emotion Regulation Difficulties. A strong positive correlation was found between Emotion Regulation Difficulties and Emotional Eating. Childhood maltreatment significantly predicted emotional eating. Emotional regulation difficulties significantly predicted emotional eating.

Conclusion: The findings indicate that childhood trauma is particularly associated with disordered eating behaviors. Additionally, it was found that emotion regulation difficulties mediate the relationship between childhood traumatic experiences and disordered eating behaviors. These results suggest that childhood traumatic experiences and emotion regulation difficulties should be considered in the treatment of disordered eating behaviors.

Keywords: Childhood Trauma, Childhood Maltreatment, Emotion Regulation, Emotion Regulation Difficulties, Emotional Eating, Disordered Eating, Mediation Analysis

Introduction

Childhood traumatic experiences (CTE) refer to a range of actions directed towards a child by caregivers, including parents and other adults. As a result of such actions, children's physical, emotional, intellectual, or sexual development may be hindered or restricted, leading to harm to physical or mental health. CTE can be categorized as childhood physical abuse (CPA), childhood physical neglect (CPN), childhood emotional abuse (CEA), childhood emotional neglect (CEN), and childhood sexual abuse (CSA) [1]. Traumatic experiences in childhood can lead to various psychological problems in the individual's adult life. One of the well-known psychiatric consequences is eating disorders [2] and emotional eating (EE). The prevalence of eating disorders in society is considerable. Overall, 5.5-17.9% of young women and 0.6–2.4% of young men have experienced a DSM-5 eating disorder by early adulthood [3]. EE is characterized by irregular eating behavior that involves overeating in response to emotional states, often defined as an increase in food consumption in the face of negative emotions [4]. While there have been various explanations for the relationship between emotions and eating behavior, the prevailing view is that EE is exhibited as an attempt to alleviate negative and distressing

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feelings or experiences [5]. EE poses a risk in terms of disordered eating commonly observed at subclinical levels in society, including binge eating disorder, night eating syndrome, overeating, purging, restrictive eating, and preoccupation with food [6].

Research on CTE and disordered eating has highlighted CTE as an important factor consistently associated with adult obesity and higher BMI [7, 8]. There is evidence suggesting that CTE shows unique relationships with disordered eating behaviors such as impulse control problems, body dissatisfaction, and eating and purging behaviors [9]. Studies have highlighted that CTE is linked to difficulties in impulsivity, which put individuals at higher risk for developing various psychopathologies like eating disorders [10]. While research has provided evidence of a relationship between CTE and eating disorders, it remains unclear which specific mechanisms are at play in this connection [11]. Indeed, evidence suggests that emotional regulation difficulties may be a potential mediator in the relationship between CTE and eating disorders, emphasizing that these difficulties likely stem from CTE and are associated with disordered eating-highlighting the potential role of emotion regulation as a mediator. Considering these findings, there is a need to better understand the relationships between different forms of CTE and different presentations of Disordered Eating, as well as the mediating psychological mechanisms that connect CTE to Disordered Eating. One of these mediating factor is considered to be Emotion regulation which can be defined as a multifaceted process that influences various factors related to emotions in individuals. [12] and which develops through positive parent-child interactions in early childhood and interactions with peers during childhood [13].

It is thought that an environment specific to abuse and neglect, where a child's emotions are ignored or punished, can lead to difficulties in identifying, expressing, and managing emotions [14]. Research has supported the idea that CTE may disrupt the development of adaptive emotion regulation skills and promote maladaptive emotion regulation [15]. In a longitudinal study comparing maltreated and non-maltreated children, Emotion regulation dysfunction was significantly associated with CTE, as well as with the earlier onset of maltreatment and experiencing multiple forms of maltreatment. [16] Authors have found evidence for cumulative effects of experiencing multiple CTE subtypes on emotion regulation development. Also experiencing CTE was determined to be predictive of impaired emotion regulation. Specifically, children who experienced maltreatment showed significantly lower emotion regulation compared to nonmal treated children, whereas children who experienced a later onset did not. [16]. Another study found that maltreated children exhibited less adaptive emotion regulation and more emotional dysregulation compared to a control group [17].

Difficulties on emotion regulation are also characteristic features of individuals with eating disorders. For example, having an Emotion regulation difficulties has predicted Disordered Eating scores in a male college population [18], and children reporting a loss of control over eating have used significantly more maladaptive Emotion regulation strategies to manage anxiety compared to a control group [19]. The idea that disordered eating behaviors may serve as a way to "block" strong emotions [20] or to distance oneself from distressing cognitions or negative mood has been suggested [21]. This notion is supported by qualitative research which found that

individuals with anorexia and bulimia viewed avoiding or getting rid of emotions as positive aspects of their illnesses [22].

Evidence of indirect pathways from CTE to EE through emotion dysregulation has increased in recent years [15, 23]. Michopoulos and colleagues [23] have suggested that targeting aspects of emotion regulation may be beneficial in the treatment of eating disorders, including EE. Moulton and colleagues [24] found significant indirect effects of CTE and eating behavior disorder through emotion dysregulation and dissociation. However, emotion regulation is a complex theoretical construct. While evidence has shown a relationship between CTE and disordered eating, the psychological mechanisms underlying these connections have not been definitively established. Therefore, the present study aims to address this gap in the literature by exploring the specific psychological mechanisms linking early trauma to disordered eating behaviors. Specifically, we aimed to investigate whether emotion regulation difficulties mediate the relationship between EE and different types of CTE subtypes. Based on the theoretical framework, we hypothesize that: (H1) Childhood traumatic experiences will positively and significantly predict emotional eating. (H2) Childhood traumatic experiences will positively predict emotion regulation difficulties. (H3) Emotion regulation difficulties will fully mediate the relationship between childhood traumatic experiences and emotional eating.

Materials and Method

Ethical approval for the study was obtained through the non-interventional ethics committee of Haliç University prior to the study with the number 206 on 26.09.2023. The personal data form and scales used in the study were transferred to Google Forms. Subsequently, data were collected through sharing links via various social media platforms, provided that individuals voluntarily chose to participate in the study. The participants reached through which through Instagram, Facebook and Twitter (X). In the study, a personal data form prepared by the researchers, along with the Childhood Trauma Questionnaire, the Emotion Regulation Difficulties Scale, and the Emotional Eating Scale were used. In this cross-sectional study, necessary information concerning the questionnaires and the aim of the study was given to the participants prior to the study via informed consent form. In case of questions that the participants do not understand, the explanation is made by the authors via their mails given at the end of the informed consent form. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Individuals who can't speak Turkish, who are not able to talk, who were illiterate, who were under 16 years old, or over 68 years old were not included in the study. Those with serious psychiatric (such as Intellectual disability, autism, dementia, chronic schizophrenia etc.) or neurological diseases (vascular dementia etc) affecting cognitive functions were excluded. The scientific rationale for these exclusion criteria is that severe neurocognitive and psychotic conditions can significantly impair cognitive functions, self-awareness, and reading comprehension, thereby compromising the reliability and validity of the retrospective self-report scales used to assess trauma and eating behaviors. The participants' psychiatric backgrounds and alcohol/substance misuse histories were not verified. The study was based only on the participants' self-reports. The participants were not diagnosed with an eating disorder according to current diagnostic classification

systems such as DSM and ICD. The eating behaviors of the participants were only evaluated by self report scales.

Participants

A total of 250 individuals aged between 16 and 68 were included in the study between October 1, 2023, and November 1, 2023.

Instruments

Personal Data Form: The following information was collected using a personal data form: gender, age, marital status, educational background, employment status, whether they have children, whether they have ever consulted a psychiatrist for psychiatric reasons, whether they are currently using psychiatric medication, whether they have ever sought psychotherapy, whether they have ever consulted a dietitian for weight gain or weight loss motivation at any point in their lives, a history of medical illness requiring medication, whether there is a history of any psychiatric illness in their family, whether they have ever used alcohol to a level requiring treatment at any point in their lives, whether they have ever used any psychoactive substances (marijuana, ecstasy, cocaine, etc.), whether they have attempted suicide before the age of 18, and whether they have attempted suicide after the age of 18.

Childhood Trauma Questionnaire (CTQ-28): This 28-item retrospective questionnaire investigates the presence of the traumatic experiences such as abuse and neglect during childhood and adolescence. This self-reported form consists of five sub-dimensions as emotional neglect, physical neglect, sexual abuse, emotional abuse, and physical abuse. The CTQ, developed by Bernstein et al.[27] (1994) to screen for traumatic experiences before the age of 18, consists of 40 items rated on a 5-point Likert-type scale. The scale was adapted to Turkish by Aslan and Alparslan (1999) [29]. In a reliability study conducted on university students, the internal consistency coefficient of the scale was found to be .96 for the entire scale and between .94 and .96 for the subscales [28]**.** In the current study, the internal consistency coefficient was found to be α = .92 for the entire scale. For the subscales, α = .81 for emotional abuse and emotional neglect, α = .90 for physical abuse, and α = .83 for sexual abuse.

Emotion Regulation Difficulties Scale (DERS-36): The Emotion Regulation Difficulty Scale-8 was developed by Penner, Steinberg, and Sharp (2022). The scale has Turkish validity and reliability. The scale, which explains emotion regulation difficulty with fewer items, consists of a total of 8 items and four sub-dimensions: purpose, impulse, non-acceptance, and strategy [29]. Each item of the thirty-six-item scale is evaluated using a 5-point Likert-type scale (1= never...5= always). A high score obtained from the scale indicates an increase in the experienced difficulty in emotion regulation. The Turkish adaptation of the scale, validity, and reliability studies were conducted by Rugancı (2010) [30]. A high score obtained from ERDS means an increase in the experienced difficulty in emotion regulation. In the results obtained from the Turkish adaptation, the Cronbach's Alpha internal consistency coefficient of the scale was found to be .94. The internal consistency coefficients of its subdimensions ranged between .90 and .75. The test-retest reliability of DRGÖ is .83, and the Guttman split-half reliability coefficient is .95 [30]. The Cronbach's Alpha internal consistency coefficient of the scale calculated for this study is .90. In the current study, the internal consistency coefficient for the entire scale was α = .95. The internal consistency coefficients of the sub-dimensions vary between .91 and .73. (“Awareness” 0.73, “clearness” 0.84, “non-acceptance” 0.89,

"strategies" 0.91, "impulse control" 0.85 and "purpose 0.85" were found.

Emotional Eating Scale (EES): The 30-item scale developed by Bilgen (2018) consists of four subscales. It includes sub-dimensions related to eating in stressful situations, eating to cope with negative emotions, self-control in eating, and control in response to stimuli [31]. The "Development, Validity and Reliability of Turkish Emotional Eating Scale" study conducted by Sinem Bilgen in 2018 aims to measure emotional eating. As a result of the three test-retest stages of the scale, Cronbach's Alpha internal consistency coefficient was determined as 0.96. In the current study, the internal consistency coefficient for the entire scale was α = .97. The internal consistency coefficients of its sub-dimensions ranged between .95 and .76. (Eating in stressful situations 0.95, Eating to Cope with Negative Emotions 0.95, Self-Control in eating 0.79, Control in response of Stimuli 0.76)

Statistical Analysis

The data obtained for the study were transferred to an electronic database. Normality distribution was assessed using the Shapiro-Wilk test. In descriptive statistics, data conforming to a normal distribution were presented as mean ± standard deviation. Pearson Product-Moment Correlation Analysis was conducted to determine the relationships between variables. To test whether emotion regulation difficulties mediated the relationship between childhood traumatic experiences (CTE) and emotional eating (EE), a simple mediation analysis was performed using the Hayes PROCESS Macro (Model 4). To ensure the robustness of the model, participant age, gender, and education level were entered as covariates. Bootstrapping with 5,000 resamples was utilized to obtain 95% confidence intervals for the indirect effect. The significance level was set at $p < 0.05$.

Table 1. Findings Regarding Participants' Socio-Demographic Characteristics

	Groups	N	%
Sex	Female	215	86
	Male	35	14
Age	18 years and under	7	2.8
	19-25 Years Old	69	27.6
	26-35 Years Old	91	36.4
	36-45 Years Old	67	26.8
	46-55 Years Old	10	4
	56 years and above	6	2.4
Marital Status	Single	142	56.8
	Married	94	37.6
	Widowed/Divorced	14	5.6
Education	Primary education	1	0.4
	High school	11	4.4
	License	121	48.4
	Postgraduate	117	46.8
Employment	Working	92	36.8
	Not working	158	63.2
Having Child/Children	Yes	68	27.2
	No	182	72.8

Results

The study included 250 participants, comprising 215 females (86%) and 35 males (14%) between the ages of 16 and 68. The average age of the participants was found to be 31.63 (± 9.5). Sociodemographic data related to the participants are presented in Table 1. 5.2% (n=13) of the participants had a BMI below 18.5, indicating they were underweight, while 50.8% (n=127) fell within the normal weight range of 18.5-24.9, and 44% (n=110) were categorized as overweight with a BMI between 25 and 29.9. The average score for participants' EES scores was determined to be 83.24 ± 30.99 (34-148).

Table 2. Means and Standard Deviations of Variables

	Mean	Standard Deviation
CTQ total	72	18
Physical abuse	32.1	10.9
Emotional abuse and neglect	32.4	7.8
Sexual abuse	7.08	3.6
ERDS total	88.3	
Awareness	12.4	3.8
Clearness	11.7	4.1
Non-acceptance,	14	6.09
Impulse Control	12.7	4.6
Purpose	16.3	3.7
Strategy	20.6	8
EES total	83.2	30.9
Eating in stressful situations	29.6	12.8
Eating to cope with negative emotions	26.4	12.3
Self-control in eating	17.4	5.4
Control in response to stimuli	9.6	3.1

CTQ: Childhood Trauma Questionnaire; ERDS: Emotion Regulation Difficulties EES: Emotional Eating Scale

The average total score for participants' DERS-36 was determined to be 88.32 ± 24.06 (38- 161). The average total score for participants' CTQ-28 was determined to be 71.66 ± 17.74 (43-126). The means and standard deviations of the variables used in the study are presented in Table 2. According to the correlation analysis, a positive, moderate (r=0.39), and significant relationship was found between CTQ-28 and DERS-36 (p<0.01). There was also a weak, positive, and significant relationship (r=0.28, p<0.01) between CTQ-28 and EE Additionally, a significant, moderate positive relationship (r=0.47, p<0.01) was identified between DERS 36 and EE. Correlations between scales are presented in Table 3.

A simple mediation analysis was conducted using the Hayes PROCESS Macro (Model 4) to examine the mediating role of emotion regulation difficulties in the relationship between childhood traumatic experiences (CTE) and emotional eating (EE). To ensure the robustness of the model, participant age, gender, and education level were entered as covariates.

Table 3. Findings Regarding the Correlation Relationship Between Main Variables

	CTQ	ERDS	EES
CTQ	-	0.39**	0.28**
ERDS	0.39**	-	0.47**
EES	0.28**	0.47**	-

*p<0.05. **p<0.01, CTQ: Childhood Trauma Questionnaire; ERDS: Emotion Regulation Difficulties EES: Emotional Eating Scale

After controlling for the covariates, the results indicated that CTE significantly and positively predicted emotion regulation difficulties (a-path) (B = 0.49, SE = 0.07, t = 6.23, p < 0.001). Furthermore, emotion regulation difficulties significantly and positively predicted emotional eating behavior (b-path) (B = 0.54, SE = 0.08, t = 6.85, p < 0.001).

Crucially, when the mediator (emotion regulation difficulties) was included in the model alongside the covariates, the direct effect of CTE on emotional eating (c'-path) was non-significant (B = 0.18, SE = 0.10, t = 1.72, p= 0.087). The bootstrapping results based on 5,000 resamples confirmed a significant indirect effect of CTE on emotional eating through emotion regulation difficulties, as the 95% confidence interval did not include zero (Indirect Effect = 0.27, BootSE = 0.06, 95% CI [0.16, 0.39]). The loss of significance in the direct effect upon introducing the mediator confirms a full mediation effect, even after controlling for age, gender, and education. The full model explained 26% (R^2 = 0.259) of the variance in emotional eating behavior.

Table 4. Mediation Analysis of Emotion Regulation Difficulties on the Relationship Between Childhood Traumatic Experiences and Emotional Eating, Controlling for Demographic Variables

Predictors	Mediator (ERD)		Outcome (EE)	
	B (*SE*)	*p*	*B* (*SE*)	*p*
Covariates				
Gender	-3.61 (4.07)	0.376	-11.86 (5.04)	0.019
Age	-0.46 (0.15)	0.002	0.14 (0.19)	0.448
Education	1.15 (2.30)	0.617	5.01 (2.85)	0.080
Main Variables				
CTQ (Path *a* / Path *c'*)	0.49 (0.07)	< .001	0.18 (0.10)	0.087
ERD (Path *b*)	—	—	0.54 (0.07)	< .001
Model Summary				
R^2	0.19		0.26	
F	14.53		17.09	

CTE: Childhood Traumatic Experiences ERD = Emotion Regulation Difficulties ; EE = Emotional Eating. Unstandardized coefficients (*B*) and standard errors (*SE*) are reported. Bootstrap confidence interval for the indirect effect = [0.16, 0.39]. Both models were statistically significant at $p < .001$.

Discussion

One of the mechanisms through which early-life traumatic experiences contribute to psychopathology is the disruption of emotion regulation. This study investigated whether emotion regulation mediated the relationship between CTE and EE, testing this potential mediating pathway. Based on previous researches [9,15] it has been assumed that there would be significant correlations between CTE, disordered eating behavior, and emotion regulation. Furthermore, it has been hypothesized that maladaptive emotion regulation would mediate the relationship between both abuse and neglect and disordered eating.

Our study has found a strong positive correlation between CTE and EE. Our results support the hypothesis that CTE has an impact on eating behavior [9, 15]. According to a recent meta-analysis [32], it has been consistently found that the rates of CTE are high in eating disorder samples, especially in individuals with Bulimia Nervosa [33-35]. In addition, research in the field has shown that irregular eating behavior is associated with a history of CSA[36,37], CPA[36,38], CPN [38], and CEA [36]. These findings suggest that these traumatic experiences may have an impact on the development of irregular eating behaviors [9, 15, 32-38]. For instance, the association between CTE and irregular eating behaviors emphasizes the psychological effects of CSA on individuals [36, 37]. Victims of CTE may be individuals who are more likely to experience emotion regulation difficulties and, as a result, may be more prone to EE behaviors. The association of CPA[36,38] and CPN[36] with irregular eating behaviors underscores the negative effects of traumatic experiences during childhood on eating habits and emotion regulation. CPA or CPN may influence individuals' coping strategies with stress, potentially leading to irregular eating behaviors. The association of CEA[36] with irregular eating behaviors highlights the impact of emotional trauma during childhood on eating habits. The study conducted by Burn and colleagues supported the hypothesis that a history of CEA has an impact on disordered eating behaviors. In this study, significant relationships were found among childhood abuse types, including physical, sexual, and emotional abuse. It was determined that emotional abuse was the only type of abuse consistently associated with symptoms of

disordered eating behaviors. Individuals exposed to emotional abuse may be more likely to experience difficulties in emotion regulation, which can contribute to EE behaviors. These research findings demonstrate the significant role of traumatic experiences during childhood in the understanding of irregular eating behaviors.

In a study conducted by Strodl and Wylie [40], the direct and indirect effects between CTE and eating behavior were examined. They found a significant direct relationship between CEA and cognitive restraint and between CTE and EE. Additionally, in the study, numerous indirect effects were identified between CTE measurement and the three measures through negative beliefs about emotions. However, the magnitude of these effects suggests the presence of other mediating variables that could be potential targets for psychological interventions for disordered eating. While researchers have emphasized the connections between CTE, emotion processing, and irregular eating behaviors [25,26], only a limited number of studies have tested the relationships between these three variables, and they have tended to focus on alexithymia [40, 41]. In the studies conducted so far, the relationships between CTE, emotion processing, and irregular eating behaviors have been explored, with a particular focus on the presence or absence of alexithymia [40, 41]. Similarly, in a sample of undergraduate female students, a weak relationship was found between CEA and irregular eating, but this relationship was mediated by alexithymia and general distress [42]. It is acknowledged that to gain a deeper understanding of emotional processes in eating disorders, it is necessary to go beyond alexithymia.

Our study found that CTE significantly predicted EE, and emotion regulation difficulties also significantly predicted EE. Our study's results have been interpreted similarly to the findings of a study conducted by Dawson et al. in 2022 [15]. In this self-report questionnaire study involving 1,254 female university students, it was found that there is a positive relationship between emotion regulation dysfunction and eating disorder symptoms. Additionally, it was observed that emotion regulation dysfunction mediated the relationship between CEA and disordered eating behavior [15]. In their relevant study, two different components of emotion regulation (expressive suppression and cognitive reappraisal) and three components of cognitive emotion regulation (intrusive thoughts, thought suppression attempts, and successful thought suppression) were examined as potential psychological mechanisms mediating the relationship between various forms of CTE and disordered eating behaviors. The data were collected using an online survey in a sample of the Australian community, with a total of 461 participants included in the study. The research identified significant mediating pathways between all forms of CTE and eating behaviors (cognitive restraint, uncontrolled eating, and EE). In a study conducted in 2014 by Mills and colleagues [42] with 226 middle school students attending a rural state school in the United Kingdom, both CEA and CEN were found to be significantly positively correlated with EAT-26 total scores. Furthermore, in the study, both CEA and CEN were found to be significantly positively correlated with dysfunctional emotion regulation and negatively correlated with functional emotion regulation. It was also observed in the study that dysfunctional emotion regulation was correlated with disordered eating scores ($p < .001$), while functional emotion regulation did not show such a correlation ($p = .82$). When disordered eating was regressed on CEA and emotion regulation, it was concluded that since CEA still explained a significant portion of the

variance in disordered eating, dysfunctional emotion regulation did not account for all the variance in the relationship between the two variables. Possible explanation about the mediating role of emotion regulation between CTE and EE can be insecure attachment relationships. Maltreated children are more likely to develop insecure attachment relationships with their caregivers, leading to difficulties with emotion regulation, which in turn may place these youngsters in pathways to problematic peer relations and behavioral maladjustment.

It should be acknowledged that this study has several limitations. First, the cross-sectional design does not allow definitive conclusions regarding causal relationships or temporal sequencing among childhood traumatic experiences (CTE), emotion regulation, and emotional eating (EE). Although the mediation analysis was theoretically based on the assumption that CTE may influence emotion regulation, which may subsequently contribute to EE, longitudinal studies are needed to establish the temporal development and directionality of these associations. Second, the study relied exclusively on self-report measures, which may be subject to reporting and recall biases, particularly regarding the retrospective assessment of CTE and eating behaviors. In addition, participants' psychiatric histories, physical illnesses, and alcohol or substance misuse histories were not independently verified. Third, the study was conducted in a non-clinical sample, and participants were not clinically diagnosed with an eating disorder according to current diagnostic classification systems such as the DSM or ICD; therefore, the findings should not be generalized directly to individuals with clinically diagnosed eating disorders. Finally, the sample was predominantly female (86%), which may limit the generalizability of the findings to male populations. Future studies should include more gender-balanced samples and longitudinal designs, as well as clinically diagnosed populations, to further examine the robustness and temporal nature of the proposed mediation mechanisms.

Conclusion

CTE are common, and they can lead to lifelong physical and mental health problems, including an increased risk of eating disorders. The long-term success of current treatments for eating disorders and EE is limited, partly because the relevant psychological processes are not well understood. Therefore, our study, by testing EE as a mediating variable in the relationship between CTE and EE, is believed to make significant contributions to the literature.

This study examined the relationship between CTE and emotion regulation difficulties, as well as the impact of emotion regulation difficulties on disordered eating behaviors. The findings indicate that childhood trauma is particularly associated with disordered eating behaviors. Additionally, it was found that emotion regulation difficulties mediates the relationship between CTE and disordered eating behaviors. These results suggest that CTE and emotion regulation difficulties should be considered in the treatment of disordered eating behaviors. Specifically, therapists should focus on improving emotion regulation skills in individuals with a history of CEA. Furthermore, therapeutic interventions should be developed to reduce the impact of emotion regulation difficulties on disordered eating behaviors. Addressing CTE and restoring emotional well-being is essential for individuals seeking to cope with and manage irregular eating behaviors. In this context, therapy and support services can assist these individuals and contribute to reducing the

effects of irregular eating behaviors. To clarify the direction of causality and the predictive role of emotion regulation strategies in mediating the relationship between CTE and EE, further longitudinal studies are needed.

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