

A STUDY EXPLORING THE RELATIONSHIP
BETWEEN EATING DISORDERS AND BORDERLINE PERSONALITY

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Abstract

The relationship of eating disorders and borderline personality captures attention as considerable number of eating disorder patients do not respond to treatments as well as the others. It was speculated that some of these patients also suffer from characterological pathology that affects the treatment process and outcome. Therefore, the current study focused primarily on the prevalence of borderline personality disorder among eating disorders and also investigated the possible relationship between borderline features and unhealthy eating attitudes and behaviors. 90 participants; 30 eating disorder patients, 30 patients diagnosed with any other Axis-I disorder, and 30 university students were included to the study. The socio-demographic and clinical forms, EAT-40 and BPI were used as instruments. The results indicated that BPI scores did not differ among eating disorder groups and control groups. Nevertheless, 11.1% of the patients diagnosed with anorexia nervosa, 33.3% of binge-eating disorder, and 41.5% of bulimia nervosa suited the criteria for borderline personality. On the other hand, only 20% of the Axis-I patients received borderline personality disorder diagnosis. Moreover, the regression analysis results yielded a significant positive relationship between borderline features and unhealthy eating attitudes and behaviors, when patients diagnosed with anorexia nervosa was removed from the sample. Additionally, female participants and high SES participants displayed higher unhealthy eating attitudes and behaviors. Finally, alcohol users, binge-eaters and night-eaters displayed significantly higher levels of borderline features.

Özet

Yeme bozukluğu tanısı alan hastaların bir kısmının tedaviye yanıt vermemesi, yeme bozuklukları ve sınır kişilik arasındaki ilişkiye dikkat çekmektedir. Bu hastaların ayrıca tedavi sürecini etkileyen karakter patolojileri olduğu düşünülmektedir. Bu nedenle, bu çalışma özellikle yeme bozuklukları ve sınır kişilik bozukluğunun birlikte görülme sıklığına ve aralarındaki olası ilişkiye odaklanmıştır. 30 yeme bozukluğu, 30 Eksen-1 bozukluğu ve 30 üniversite öğrencisi olmak üzere 90 kişi bu çalışmaya katılmıştır. Sırasıyla, sosyo-demografik ve klinik bilgi formu, Yeme Tutum Testi (EAT-40) ve Borderline Kişilik Envanteri (BPI) kullanılmıştır. Sonuçlar, gruplar arasında BPI'nin farklılık göstermediği yönündedir. Ancak, anoreksiya nervosa tanısı konmuş hastaların % 11.1'inin, tıkanırcasına yeme bozukluğu tanısı almışların % 33.3'ü ve bulimiya nervosa tanısı almışların %41.5'inin borderline kişilik bozukluğu kriterlerini doldurduğu bulunmuştur. Bunun yanı sıra, Eksen-1 tanısı almış hastaların ancak % 20'si bu kriterlere uymaktadır. Regresyon analiz sonuçları, anoreksiya nervosa tanısı almış hastalar örneklemden çıkartıldığında, borderline kişilik ve sağlıksız yeme tutum ve davranışları arasında pozitif bir ilişki göstermiştir. Ayrıca, kadınların ve yüksek sosyo-ekonomik düzeydeki katılımcıların daha yüksek oranda sağlıksız yeme tutum ve davranışları sergilediği bulunmuştur. Son olarak, alkol kullanımı, tıkanırcasına yeme ve gece yeme alışkanlıkları olanların daha yüksek oranda borderline özellikler sergiledikleri görülmüştür.

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A Study Exploring the Relationship Between Eating Disorders and Borderline Personality Disorder

Eating disorders, defined as a general category of serious pathology in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR (American Psychological Association [APA], 2001), are considered to be one of the most widespread mental health problems. From the late 1960's, concepts like body image, weight, and eating behavior problems attracted substantial level of attention. Especially, over the past decades, eating disorders have progressively become recognizable for the burdens they bring to general functioning in life (Shipton, 2004). Accordingly, this particular pathology is a great interest to the public, researchers, and clinicians, and the number of studies in this area keeps growing.

Aside from the studies that primarily focus on eating disorders, the prevalence of other psychiatric disorders that accompany this pathology attracts attention. Considering the fact that most patients diagnosed with eating disorders also suffer from significant characterological pathology (Kernberg, 1995), it is understandable that the relationship between personality disorders and eating disorders is one of the most frequently studied topics in literature (Batum, 2008; Bemporad et al., 1992; Dennis & Sansone, 1997; Godt, 2002; Godt, 2008; Lilienfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006; Livesley, Jang, & Thordarson, 2005; Maranon, Echeburua, & Grijalvo, 2004; Matsunaga, Kiriike, Nagata, & Yamagami, 1998; Ro, Martinsen, Hoffart, & Rosenvinge, 2005; R.A.Sansone, Levitt, & L.A. Sansone, 2005; Cassin & von Ranson, 2005; von Ranson, 2008; Wonderlich & Mitchell, 2001; Wonderlich, 2002). Indisputably, remarkable studies have evolved around the possible relationship of borderline personality organization, borderline personality disorder, and eating disorders (Kernberg, 1995; Livesley et al., 2005; Nooring, 1993; Sansone & Levitt, 2005; Sansone & Levitt, 2006; Shipton, 2004).

The aim of the current project is two-fold. One aim is to trace the history of the borderline personality disorder. The second aim is to investigate the prevalence of borderline personality disorder among patients diagnosed with eating disorders; a topic which I believe deserves immediate consideration as their comorbidity creates serious complications regarding treatment process (Abbott et al., 2001; Dennis & Sansone, 1997; Kernberg, 1995; Levitt, 2005; Wonderlich, 2002; Wonderlich & Swift, 1990). In this context, the possible relationship between borderline features and unhealthy eating attitudes and behaviors are also explored.

A. Introduction to Eating Disorders

Fairburn and Walsh (2002) proposed a definition of eating disorder as; '*a persistent disturbance of eating behavior or behavior intended to control weight, which significantly impairs physical health or psycho-social functioning*' (p.171).

As a diagnostic group, eating disorders are primarily divided into three main categories; Anorexia Nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified (APA, 2001). In addition, 'Binge-Eating Disorder' is a newly recognized form of eating disorders, which is currently classified under Eating Disorders Not Otherwise Specified.

Anorexia Nervosa

Anorexia nervosa is the very first defined diagnostic category of eating disorders. The essential features of anorexia nervosa are that the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of her/his body (APA, 2001). It has been suggested that weight loss is experienced as an accomplishment and a sign of self-control, and discipline (PDM, 2006; Smith, 2008).

In 1970, Russell defined the cardinal feature of anorexia nervosa as 'a morbid fear of becoming fat' and stated three main diagnostic criteria (as cited in Gürdal, 1997, p.31; as cited in Hsu, 1990, p. 115):

1. *The patient's behavior leads to a marked loss of body weight and malnutrition, behavior that includes fasting, selective carbohydrate refusal, self-induced vomiting, purgative abuse, or excessive exercise.*
2. *There is an endocrine disorder that manifests itself clinically by amenorrhea in the female and loss of sexual interest and potency in the male; and*
3. *There are present a variety of mental attitudes, such as a morbid fear of becoming fat, a belief to be thin is to be desirable, a loss of judgment regarding food intake and body weight, and sometimes depressive and phobic symptoms.*

The two subtypes of anorexia nervosa were defined as; (a) Restricting type: weight loss is due to diet and excessive exercise, and (b) Binge-eating/Purging type: weight loss is due to self-induced vomiting and/or the misuse of laxatives, diuretics, or enemas.

The DSM-IV-TR (APA, 2001) and the ICD-10 (WHO, 1992) diagnostic criteria for anorexia nervosa are presented in Appendixes A and B respectively.

Bulimia Nervosa

Bulimia, meaning '*great hunger*' (Holmes, 2001, p. 399), is another diagnosis among eating disorders. As a word, bulimia was taken from the Greek *bous* (ox) and *limos* (hunger), symbolizing the individual's capacity to eat an entire animal (Beumont, 2002; Vandereycken, 2002). As the word itself implies, bulimia nervosa is characterized with recurrent and uncontrolled episodes of huge amount of food ingestion, efforts to control weight with methods such as vomiting, laxative and diuretic abuse, using of diet pills, fasting, dieting, excessive exercising, chewing and spitting out food, and rumination (Berkman, Lohr, & Bulik, 2007; Crow & Mitchell, 2001; Kernberg, 1995; Morais & Horizonte, 2002).

Bulimia nervosa was first described by Russell in 1979 with three main diagnostic criteria (p.445):

1. *The patients suffered from powerful and intractable urges to overeat,*
2. *They seek to avoid the 'fattening effects' of food by inducing vomiting or abusing purgatives, or both,*
3. *They have a morbid fear of becoming fat.*

The DSM-IV-TR (APA, 2001) and the ICD-10 (WHO, 1992) diagnostic criteria for bulimia nervosa are presented in Appendixes C and D respectively.

Atypical Forms of Eating Disorders

Anorexia nervosa and bulimia nervosa were commonly known forms of eating disorders. However, a high percentage of individuals who should receive a diagnosis, just do not fit the standard classification profiles (Fairburn & Walsch, 2002; Keel, 2001). In other words, although these atypical cases suffer from clinically significant eating disorders, they fail to fulfill all diagnostic criteria (quantitatively or qualitatively) of neither anorexia nervosa nor bulimia nervosa (Fairburn & Walsch, 2002; Keel, 2001).

The classification system of these atypical cases have been subject to harsh criticisms as the majority of eating disorders patients were diagnosed neither with anorexia nervosa nor with bulimia nervosa, but with eating disorders not otherwise specified, EDNOS (Fairburn, 2007; Striegel-Moore & Bulik, 2007). Fairburn (2007) stated that the high frequency of the EDNOS diagnosis could be well explained as a handicap; while the patients could not easily meet diagnostic criteria, it is practical to classify these cases under EDNOS as no diagnostic criteria is required.

Binge-Eating Disorder

It is clinically known that a large number of individuals present recurrent episodes of compulsive eating (de Zwaan & Mitchell, 2001; Morais & Horizonte, 2002). These individuals uncontrollably ingest huge amounts of food in relatively short periods of time, and unlike

bulimics, they do not engage in regular use of compensatory behaviors, such as vomiting or laxative use (Grilo, 2002; Morais & Horizonte, 2002; Walsh & Garner, 1997). It is common that, individuals suffering from binge-eating disorder are above the expected body mass index and usually, but not necessarily (de Zwaan & Mitchell, 2001; Onar, 2008), diagnosed with obesity (de Zwaan & Mitchell, 2001; Gürdal Küey, 2008a; Gürdal Küey, 2008b; Grillo, 2002). On the other hand, similar to individuals diagnosed with bulimia nervosa, the feelings of loss of control could be stated as one of the main features of binge-eating disorder (de Zwaan & Mitchell, 2001; Gürdal Küey, 2008b; Waller, 2002). As expected, no significant relationship was found between feeling hungry and binging (de Zwaan & Mitchell, 2001).

Regardless of all questions that remain unanswered about the diagnosis, prognosis, and treatment, binge eating disorder (BED) was introduced in DSM- IV (APA, 1994) as a provisional eating disorder diagnosis and recently included in the list of possible new diagnostic categories of the DSM-IV-TR (APA, 2001). The provisional diagnostic criteria of binge eating disorder are presented in Appendix E.

B. Epidemiology of Eating Disorders

The prevalence of anorexia nervosa, which is known to have the highest mortality rate among all psychiatric disorders (Gürdal Küey, 2008b; van Hoeken, Seidell, & Hoek, 2005), has been reported in a range from 0.0 % to 1.0% (Ebert, Loosen, & Nurcombe, 2000; Hoek, 2002; Hoek & van Hoeken, 2003; Kuğu, Akyüz, Doğan, Ersan, & İzgiç, 2006; Mussell et al., 2001; Sancho, Arija, Asorey, & Canals, 2007; van Hoeken et al., 2005). The reported lifetime prevalence of anorexia nervosa among women was found to be 0.3% (APA, 2006; Berkman et al., 2007; Hoek & van Hoeken, 2003). It was suggested that a more broadly defined anorexia nervosa is more common than these given rates (APA, 2006).

With regard to bulimia nervosa, the prevalence rates were found to be higher than those of anorexia nervosa, ranging from 0.0% to 4.5% (APA, 2006; Ebert et al., 2000; Demir,

Eralp Demir, Kayaalp, & Büyükkal, 1998; Fairburn & Beglin, 1990; Kuğu et al., 2006; Sancho et al., 2007). The estimates of the lifetime prevalence of bulimia nervosa were found to be approximately 1% among females (APA, 2006; Berkman et al., 2007; Fairburn & Beglin, 1990; Hoek, 2002; Hoek & van Hoeken, 2003; van Hoeken et al., 2005) and 0.1 among males (Hoek & van Hoeken, 2003).

For atypical eating disorders, EDNOS, the prevalence rate has been given in a range from 0.2% to 4.5% (Hoek & van Hoeken, 2003; Sancho et al., 2007). Moreover, binge eating disorder has been reported within the range of 0.7% to 3% (Berkman et al., 2007; de Zwaan & Mitchell, 2001; Demir et al., 1998; Hay, 1998, as cited in Striegel-Moore & Franko, 2008; Hudson, Hiripi, Pope, & Kessler, 2007, as cited in Striegel-Moore & Franko, 2008; Kuğu et al., 2006). The estimates of the lifetime prevalence of binge-eating disorder have found to be at least 1% (Hay 1998, as cited in Striegel-Moore & Franko, 2008; Hudson et al., 2007, as cited in Striegel-Moore & Franko, 2008; Hoek & van Hoeken, 2003). Furthermore, the lifetime prevalence of binge eating disorder in females have been found to be 3.5% and in males, 2.0% (Hudson et al., 2007 as cited in Striegel-Moore & Franko, 2008).

The incidence rates of eating disorders are problematic as the studies have been generally composed by screening medical records of health care providers, general practitioners and specialists (Hoek & van Hoeken, 2003). The incidence rates for anorexia have followed a seriously increasing trend till 1970's (Gürdal, 2008b; Hoek, 2002; Sancho et al., 2007). However, after 1980's, different opinions have been reported; some researchers suggested stability over time (Hoek, 2002) whereas others suggested an increasing trend (Hoek & van Hoeken, 2003; Lucas, Crowson, O'Fallon, & Melton, 1999; Pansberg & Wang, 1994 as cited in Sancho et al., 2007) especially among young women aged fifteen to twenty four. The basis of this increase has been generally explained by the public awareness of presence of

eating disorders and/or changes in diagnostic practice which also increases the chances for seeking treatment (Fairburn & Harrison, 2003).

The incidence of anorexia nervosa varied considerably from 0.10 to 12.0 per 100.000 population per year (Hoek, 2002; Hoek & van Hoeken, 2003; Sancho et al., 2007; van Hoeken et al., 2005; Lucas et al., 1999). It has been stated that eight females per 100.000, whereas 0.5 males per 100.000 are diagnosed with anorexia nervosa (Hoek & van Hoeken, 2003; van Hoeken et al., 2005; Lucas et al., 1999; Nielsen, 2001). On the other hand, regarding bulimia nervosa, the incidence rates were reported as 12 to 14 per 100.000 population per year (Hoek, 2002; Hoek & van Hoeken, 2003; van Hoeken et al., 2005; Nielsen, 2001). Aside from these given rates, it is crucial to state that, today eating disorders have become more and more heterogeneous (Hoek & van Hoeken, 2003).

Among all the psychiatric disorders, eating disorders are the most distinctive, in terms of gender differences; in fact they are regarded as the third most common form of chronic illness among girls and women (Reijonen, Pratt, Patel, & Greydanus, 2003). The male-female prevalence ratio of eating disorders was stated in a range of 1:6 to 1:10 (APA, 2006; Beattie, 1988; Hsu, 1990; PDM, 2006; Lucas et al., 1999; Reijonen et al., 2003). In other words, eating disorders are primarily a female pathology; approximately 90-95 % of individuals diagnosed with eating disorders are females, whereas approximately 5-10 % of them are males. On the other hand, an increase in eating disorders among males especially with higher prevalence of homosexual or bisexual preference has been reported (Gürdal Küey, 2008a; Gürdal Küey, 2008b; Hsu, 1990; PDM, 2006; Striegel-Moore & Bulik, 2007).

The onset of eating disorders was usually reported around adolescence (APA, 2006; Ebert et al., 2000; Hoek & von Hoeken, 2003; Hsu, 1990; Reijonen et al., 2003; Striegel-Moore & Bulik, 2007). Furthermore, as the age of entering puberty is significantly decreasing, now it is possible to see younger patients suffering from eating disorders (Crow &

Mitchell, 2001; Gürdal Küey, 2008a). The bulimia nervosa usually develops within the age range of 16 to 20 (Crow & Mitchell, 2001; Gürdal Küey, 2008a). On the other hand, the onset of anorexia nervosa is reported as earlier, around the age of 14-18 (Gürdal Küey, 2008b; Reijonen et al., 2003).

Generally, eating disorders tend to be seen in Caucasian, educated, economically advantaged, and ensconced in Western cultures (APA, 2006; Hsu, 1990; Jordan, Redding, Troop, Treasure, & Serpell, 2003; Polivy & Herman, 2002). In this conceptualization, eating disorders are seen as ‘culture bound syndrome’ suggesting that it is primarily a ‘Western’ epidemic predominantly seen in industrialized, developed countries (Crow & Mitchell, 2001; Hoek, 2002; Polivy & Herman, 2002; Smith, 2008). In this view, it is also asserted that eating disorders can be seen in individuals who have adopted and internalized Western values, Western-defined standards of beauty ideal of extreme thinness and attractiveness (Hsu, 1990; Striegel-Moore & Bulik, 2007) which promotes the objectification of the body (Morais & Horizonte, 2002) within the high or middle socio-economic status population (Polivy & Herman, 2002; Smith, 2008). Clearly, the concept of culture bound syndrome eliminates the possibility that non-Western, non-white females or individuals with low socio-economic status could develop eating disorders. In fact, reaching the medical system and in connection, seeking treatment should be evaluated as an important factor. Similarly, several findings have suggested that eating disorders do occur among non- Caucasians (Akan & Grilo, 1995; French, Story, Neumark-Sztainer, Downes, Resnick, & Blum, 1997; Hsu, 1990) and non-Western cultures. Moreover, it has been declared that there is no statistically significant difference regarding the socio-economic level of individuals with eating disorders (Vandereycken & Hoek, 1992). Furthermore, Turkish studies have revealed similar conclusions (Demir et al., 1998; Gürdal, Mırsal, & Ciğeroğlu, 1997; İzmir, Erman, & Canat, 1993; Yeşilbursa, İmre, Türkcan, & Uygur, 1992); some suggesting that even though

symptoms differ among socio-economic levels, the primary symptoms of psychopathology do not vary in different countries or socioeconomic groups (Gürdal et al., 1997). On the other hand, 'culture change syndrome' could explain eating disorders, accepting the encounter of a different culture as a triggering factor (Vandereycken & Hoek, 1992). According to this view, immigrants such as Turks and Greeks in Germany are more likely to develop eating disorders (Hoek, 2002; Vandereycken & Hoek, 1992).

It is also possible to suggest that there are high risk populations where thinness is mandatory. Eating disorders have been found to be more common in models, dancers, ballerinas and athletes (Anshel, 2004, as cited in Smith, 2008; APA, 2006; van Hoeken et al., 2005).

From a more general point of view, risk factors for eating disorders can be listed as; gender, childhood eating and gastro-intestinal problems, body image and weight concerns, negative self-evaluation, sexual abuse, alcohol and drug abuse and general psychiatric comorbidity including comorbid personality disorders.

C. Introduction to Borderline Personality Disorder

As an initial point, person means '*mask*' signifying the individual's unique way with reference to behavior and interpersonal relationships (Gökalp, 1997, p.216). In general, personality can be defined as an enduring and unique cluster of characteristics; the way an individual responds emotionally, cognitively, and behaviorally in various situations (Holmes, 2001; Schultz & Schultz, 2001).

Accordingly, personality disorder is a class of mental disorders which can be characterized by pervasive and persistent patterns of feeling, thinking, and behavior (Holmes, 2001). According to the DSM-IV-TR (APA, 2000), personality disorders are defined by maladaptive personality characteristics beginning early in life that have consistent and serious effects on functioning. The symptoms are typically marked in the areas of cognition,

affectivity, interpersonal functioning, and impulse control (Jackson & Jovey, 2006).

Personality disorders have been grouped under three clusters: Cluster A (paranoid, schizoid, and schizotypal) is characterized by odd behaviors, humorlessness and social isolation; Cluster B (antisocial, borderline, histrionic, and narcissistic) is characterized by emotional instability and distress, angry outbursts, and erratic behavior; Cluster C (avoidant, dependent, and obsessive-compulsive) is characterized by, social anxiety, avoidance, and inflexibility (Abbott, Wonderlich & Mitchell, 2001).

Definition of Borderline Personality Disorder

Sansone & Levitt (2005) defined borderline personality disorder as '*a complex Axis-II phenomenon in which affected individuals sustain a superficially intact social façade in conjunction with longstanding self-regulation difficulties and self-harm behavior, chaotic interpersonal relationships, and chaotic dysphoria* (p.71). The DSM-IV-TR (APA, 2001) and the ICD-10 (WHO, 1992) diagnostic criteria for borderline personality disorder are presented in Appendixes F and G respectively.

Borderline personality disorder is characterized primarily by instability in several areas; including interpersonal relationships, mood, identity (self-image), thoughts and behaviors (Holmes, 2001; Paris, 2005). Consistently, Dennis & Sansone (1997) summarized that borderline individuals commonly have low self-esteem associated with negative self-perception, significant difficulties in maintaining stable interpersonal relationships with others, self-regulatory deficits and impulse difficulties. Indeed, the label of 'borderline' seems to be appropriate thinking given the instability of the symptoms; moving up and backing across the borders (Holmes, 2001). Also, the name implies a chronic characterological organization which can be replaced in a borderline area between neurosis and psychosis (Kernberg, 1985).

The Conceptualization of Borderline Personality Organization/ Disorder

The co-existence of intense, erratic and unstable moods of some individuals was recognized since the earliest records of medical history. In the late 1930's, with the contributions of Stern, the concept of borderline were originally coined with an effort to conceptualize a group of patients existing between neurosis and psychosis. Stern (1938, p.55) listed and discussed several characteristics for border line group. In 1942, Deutsch (1986) introduced the concept of 'as if personality' that contributed to a more coherent understanding of borderline organization through highlighting the importance of internalized object relations.

Additionally, several other theoreticians have contributed toward a coherent understanding of borderline pathology regarding internalized object relations. Knight (1986) mentioned that although neurotic symptoms can be seen in borderline patients, they should be evaluated as camouflage of severe regression and weakening of ego functions; realistic planning, maintenance of object relationships, and defenses against primitive impulses. Jacobson (1964, as cited in 1986) investigated the vicissitudes of ego and superego formation in borderline patients and Khan (1960, as cited in Kernberg, 1985) studied the specific defensive operations and the specific pathology of object relationships in borderline patients.

Above all, Kernberg (1985) introduced the concept of 'levels of personality organization'; the most notable contribution to the literature on borderline organization. Kernberg (1985) has placed the borderline level of organization between neurotic and psychotic and believed that borderline level included the characteristics of both. According to his view, borderline personality organization is characterized by identity diffusion, ego weakness and predominance of primitive defensive operations. The aspects of ego weakness referred to some characteristics including '*lack of anxiety tolerance, lack of impulse control and lack of developed sublimatory channels*' (1985, p.22).

In Kernberg's view, there is a predominant disturbance regarding internalized object relations such that there is a reliance on primitive defensive operations including splitting, primitive idealization, projective identification, and denial. Thus, in the mechanism of splitting, 'good' and 'bad' representations are unrelated and actively separated which could be presented as the primary deficit in borderline personality organization affecting the stability of ego boundaries. Consistently, Kernberg stated the major defect in the development of borderline personality organization as individual's *'incapacity to synthesize positive and negative introjections and identifications; there is a lack of the capacity to bring together the aggressively determined and libidinally determined self and object images'* (1985, p. 28). Hence, these 'all good' and 'all bad' representations result in rapid switches between idealizing and devaluating leading to emotional flooding and chaotic interpersonal relationships. Accordingly, Kernberg mentioned a predominance of pregenital aggressive impulses stemming from a constitutionally determined intensity of aggressive drives or from severe early frustration resulting in disturbed object relations and specific ego weaknesses.

Consistent with his perspective, Kernberg (1985) believed that the borderline patients are fixated at Mahler's separation-individuation phase. According to this developmental theory, developing borderline personality organization was associated with the unsuccessful negotiation of the sub phase of separation-individuation; the rapprochement phase which is primarily characterized with the ambivalence between symbiosis and autonomy. Therefore, the mother's libidinal availability to confine and hold as well as support for independency is clearly important in order to solve the rapprochement crises. Consistently, from a theoretical point of view, a severe lack of support from primary caretaker in this particular stage leads to arrested development marked by swinging from dependency to omnipotence/ grandiosity that is a dilemma for borderline personality disorder.

In addition, Kohut studied the etiology, psychodynamics and psychotherapy of borderline personality disorder. Kohut's theory (1971; 1977) has focused on the subject of self object; the sense of cohesion, stability, and resilience of the self. According to this theory, interference at different stages of development leads to different impairments in the development of idealizing process or the grandiose self. Thus, Kohut's theory proposed that borderline personality disorder is derived from chronic deficiency of parental empathy that also blocks the development of a cohesive self.

Masterson (1981) has also believed that borderline character pathology emerges as a developmental arrest resulting from a disruption of the normal separation-individuation process. The internalization of a relationship that emphasizes the need for helplessness, compliance, and clinging as the primary condition of attachment leads to borderline pathology. In addition, in such particular developmental arrest, predominant use of primitive defenses including splitting, denial, acting out, and projective identification, as well as ego deficits in the areas of impulse control, frustration tolerance, reality perception, and ego boundaries is expected. Also, Masterson used the term '*the disorders of the self triad*' (1981, p. 133) which refers to the fact that the efforts in activation of the real self evoke an abandonment depression, followed by a defense used against this dysphoric state. In borderline personality disorder, the pathological ego, a false defensive self is designed to avoid the experience of the abandonment depression by maintaining a connection with either or both the rewarding and withdrawing part of the object.

Moreover, Fonagy, Target, Gergely, Allen, & Bateman (2003) focused on the importance of secure attachment and argued that at borderline personality disorder develops as a result of a failure to develop secure attachment, an attachment trauma such as the primary caretaker's both physical and psychological neglect and non or inadequate mirroring or containment, lack of playfulness, establishment of the 'alien self' and failure of mentalization.

As mentioned, the role of the primary caretaker and in broader sense the importance of family relationships was commonly stressed in the etiology of borderline personality disorder (Freeman et al., 2005; Kernberg, 1985; Kohut, 1971; Kohut, 1977; Mahler et al., 1975; Masterson 1981; Fonagy et al., 2003). As Freeman et al., (2005) put together fairly, according to Kohut the patient suffering from borderline personality had experienced '*insufficient mirroring from the mother*', whereas according to Kernberg, it was '*introjected negative aspects of the mother*' (p.8).

Finally, it is possible to suggest several other factors associated with vulnerability to borderline personality disorder that can be summarized as behavioral impulsivity, negative affectivity, emotional lability, substance abuse, chaotic home environment, disorganized attachment, severe or chaotic abuse/neglect or trauma and separation/ early loss (Stone & Hoffman, 2005; Hsu, 1990; Paris, 2005; Wonderlich, 2002).

D. The Relationship of Eating Disorders with Borderline Personality Disorder

Personality traits have long been proposed as a critical determinant of risk for developing an eating disorder. In the last decades, clinicians have primarily focused on the issue of whether certain mechanisms increase the risk for both eating disorders and specific personality characteristics, and the effect of personality on the clinical picture, course and treatment of eating disorders (Nording, 1993; Wonderlich, 2002).

Clinical observations and empirical research have pointed to a link between personality disorders and eating disorders, suggesting that diagnosis of personality disorders may be more common among individuals with eating disorders (Batum, 2008; Cassin & von Ranson, 2005; Dennis & Sansone, 1997) in a range of 27% to 77% (Bemporad et al., 1992; Godt, 2002; Godt, 2008; Ro et al., 2005; Wonderlich & Mitchell, 2001, Maranon et al., 2004; Matsunaga et al., 1998).

In general, the relationship of personality disorders and eating disorders has been explored through comorbidity studies. Comorbidity studies are considered to be vital for understanding the underlying psychopathology and etiology of these disorders which in turn has relevance to the clinical formulation and treatment plan (Abbott, Wonderlich, & Mitchell, 2001; Cassin, & von Ronson, 2005; Lilenfeld et al., 2006; Lilenfeld, Jacobs, Woods, & Picot, 2008; Wonderlich, 2002).

The prevalence of personality disorders among bulimic subjects has been reported to range from 0% to 84.5% (Dennis & Sansone, 1997; Sansone et al., 2005; Sansone, Fine, Seufferer, & Bovenzi, 1989). In restricting subtype of anorexia nervosa, the prevalence of personality disorders was found to be in a range from 31% to 86.7% (Dennis & Sansone, 1997; Sansone et al., 2005). Also, in binge-eating/ purging subtype of anorexia nervosa, personality disorders were reported in a range of 70% to 97.4% (Dennis & Sansone, 1997; Sansone et al., 2005). In binge-eating disorder, the prevalence of personality disorders was found to be 73.1% (Sansone et al., 2005).

In a review article presenting the noteworthy studies regarding the comorbidity of personality disorders and eating disorders, (Cassin & von Ranson, 2005), the prevalence rates of personality disorders among individuals with eating disorders were separately investigated according to the method of assessment as (a) self-report, and (b) diagnostic interview. The general point obtained from the prevalence rates of personality disorders among restricting type of anorexia nervosa, assessed by using self-report, was that the Cluster C personality disorders (particularly obsessive-compulsive personality disorder), followed by the Cluster B disorders (especially borderline personality disorder), have the highest comorbidity rates. Overall, Cluster C personality disorders were found to be predominant in restricting type of anorexia nervosa and, thus, more than a few studies have yielded similar results (Abbott et al., 2001; Berkman et al., 2007; Godt, 2002; Godt, 2008; Maranon et al., 2004; Ro et al., 2005;

Sansone et al., 2005; Wonderlich, 2002). Additionally, for binge eating/ purging type of anorexia nervosa, borderline personality disorder was found to be predominant, followed respectively by avoidant or dependent personality disorders, and histrionic personality disorder (Sansone et al., 2005). Regarding individuals with bulimia nervosa, again the Cluster C personality disorders followed by borderline personality disorder were found to be most common. In contrast, some other researchers reported that among people diagnosed with bulimia nervosa, Cluster B, the borderline personality disorder was the most frequent disorder (Abbott et al., 2001; Dennis & Sansone, 1991; Matsunaga et al., 1998; Ro et al., 2005; Sansone et al., 2005; Shipton, 2004; Wonderlich, 2002; Wonderlich & Swift, 1990). Similarly, in a review by Lilenfeld et al., (2006), it was captured that among the Cluster B personality disorders, particularly borderline personality disorder was the most common among individuals with bulimia nervosa.

The results assessed by diagnostic interview have demonstrated that the comorbidity of restricting type of anorexia nervosa and the Cluster C personality disorders were most common, whereas among individuals with bulimia nervosa, borderline personality disorder were undeniably and highly common. Furthermore, in eating disorders not otherwise specified (EDNOS) group, avoidant (Ro et al., 2005) and with a lower percentage borderline personality disorder was predominant (Godt, 2002). In addition, among individuals with binge eating disorder, the most common personality disorders were found to be avoidant, obsessive-compulsive and borderline. On the contrary, Sansone et al., (2005) have reported that obsessive-compulsive personality disorder was most common with 16%, and was followed by the avoidant and borderline personality disorders.

Sansone et al., (2005) have indicated that the personality pathology was most loaded in bulimia nervosa, then in binge-eating/purging type of anorexia nervosa, followed by binge-eating disorder, and finally in restricting type of anorexia nervosa (Sansone et al., 2005). On

the other hand, Maranon et al., (2004) have speculated that binge eating/ purging type of anorexia nervosa has the highest comorbidity with personality disorders among all subtypes of eating disorders.

Several personality traits have long been proposed as a critical determinant of risk for developing an eating disorder. A review by Lilenfeld et al., (2006) noted that negative emotionality, perfectionism, drive for thinness, poor interoceptive awareness, ineffectiveness, and obsessive personality traits were found as predisposing factors for developing eating disorders. Additionally, impulsivity, perfectionism, obsessive-compulsiveness, narcissism, and autonomy were identified as risk factors (Cassin & von Ranson, 2005; Favaro & Santonastaso, 2006; Lilenfeld et al., 2006; Johnson, Cohen, Kasen, & Brook, 2006; von Ranson, 2008).

Overall, in the literature, the relationship of anorexia nervosa, perfectionism and/or obsessive-compulsive personality disorder (Maranon et al., 2004; Ro et al., 2005; Wonderlich, 2002) and the relationship of bulimia nervosa, impulsivity and/or dramatic-erratic (Cluster B) personality disorders, specially borderline personality disorder were commonly demonstrated (Ro et al., 2005; Wonderlich, 2002; Wonderlich & Mitchell, 2001).

E. Possible Explanations for the Relationship of Eating Disorders with Borderline Personality Disorder

Levitt (2005, p.112) summarized several clinical characteristics of individuals suffering from the comorbidity of eating disorders and borderline personality disorder such as:

- *Poor social skills with pseudo-maturity*
- *Unable to cope with the demands of life*
- *Highly controlled, perfectionistic and performance-based*
- *Narrow psychological and interpersonal experiences*
- *Chaotic and frequent acting out behaviors*
- *Predominant affects of shame, guilt, and rage*

- *Loss of control*
- *Wide range of concomitant impulsive and compulsive behaviors*
- *Multiple hospitalizations*
- *Life-threatening and pseudo-life threatening behaviors.*

Additionally, Wonderlich and Swift (1990) found that in an eating-disordered population, patients with borderline personality disorder differ from other personality-disordered patients in their histories of sexual abuse, self-destructiveness, and perceptions of hostility in their parental relationships.

It has been hypothesized that there are similarities between eating disorders and borderline personality disorders regarding the affected areas of functioning including impulse management, difficulties in modulating mood and behavior, maintaining self-esteem, sustaining adequate relationships with others and constructing an identity (Sansone & Levitt, 2005; Sansone & Levitt, 2006). Several authors have suggested that eating disorder symptomology may overlap with borderline personality disorder, regarding impulsivity and affective instability (Abbott et al., 2001; Favaro & Santonastaso, 2006; Sansone & Levitt, 2005; Sansone & Levitt, 2006). Some individuals suffering from bulimia nervosa have been found to commonly display ‘unstable and intense personal relationships, potentially self-damaging impulsivity, emotional instability, inappropriate and intense anger, recurrent suicidal threats or gestures, marked and persistent identity disturbances, chronic feelings of emptiness or boredom, and fears of abandonment’ (APA, 1994). Self-destructive behaviors such as self-mutilation; cutting, burning, biting, or bruising body parts, suicide attempts, high-risk behaviors, alcohol and substance abuse or dependence, promiscuity, stealing, excessive gambling, excessive shopping are also highly common (Abbott et al., 2001; Dennis & Sansone, 1997; Favaro & Santonastaso, 2006; Hsu, 1990; Kernberg, 1995; Wonderlich 2002).

It has been speculated that eating disorder patients, in general, tend to display a higher borderline functionality, compared to other borderline patients (Sansone & Levitt, 2005; Sansone & Levitt, 2006). Dennis & Sansone (1997, p.439) explained the relationship of borderline personality with eating disorders by stating that '*eating disorder behaviors serve a variety of adaptive functions for borderline patients*' and proposed five functions: (1) the pursuit of thinness often functions to enhance the patient's extremely low self-esteem, (2) these patients usually have limited ability to self-soothe and binge-eating behaviors can be seen as a self-soothing mechanism, (3) regarding self-regulation difficulties, purging behaviors can give a sense of self-control, (4) self-destructive behaviors including self-starvation, excessive exercising, laxative use may be understood as a form of self-punishment, and (5) these behaviors can be suggested to provide a numbness against experienced intolerable emotional pain.

Moreover, Dennis and Sansone (1991) have reviewed several developmental theories that explain the ego deficits of eating disorder patients with borderline personality disorder. The main focus of these theories is the primary caretaker's role in promoting or decelerating the specific developmental tasks that the infant experience. Their conclusion was that a severe disruption in infants' early relations interferes with the ability to internalize and structuralize important ego skills including impulse control, problem solving, object relatedness and affect modulation.

In addition to all, several etiological models were proposed explaining the relationship of borderline personality disorder with eating disorders. According to the common cause model, although borderline personality disorder and eating disorders share a common etiology; they may have different symptom presentations and/or disease processes (Batum, 2008; Lilienfeld et al., 2006; Sansone & Levitt, 2005; Sansone & Levitt, 2006). For instance, this model assumes that a factor such as childhood trauma may increase the risk for developing

both borderline personality disorder and an eating disorder. The spectrum model also suggests that borderline personality disorder and eating disorders share the same underlying etiology but this model assumes that they are not distinct disorders by means of mechanisms of action (Batum, 2008; Lilenfeld et al., 2006; Sansone & Levitt, 2005; Sansone & Levitt, 2006). Moreover, this model assumes that eating disorders represent a variant of and/ or a milder form of borderline personality disorder (Batum, 2008; Lilenfeld et al., 2006; Sansone & Levitt, 2005; Sansone & Levitt, 2006).

The predispositional model suggests that etiologies of borderline personality disorder and eating disorders are different and that disorder increases the likelihood/risk of developing the other (Batum, 2008; Jackson & Jovev, 2006; Lilenfeld et al., 2006; Sansone & Levitt, 2005; Sansone & Levitt, 2006). For instance, several studies have conducted to investigate whether traits as impulsivity, perfectionism, narcissism, autonomy and many more increases the risk of developing eating disorders (Cassin & von Ranson, 2005; Favaro & Santonastaso, 2006; Lilenfeld et al., 2006; Johnson, Cohen, Kasen, & Brook, 2006; von Ranson, 2008).

According to the pathoplasty model, the etiology of borderline personality disorder and eating disorders are independent; however, these two conditions interact in such a way that modifies the presentation and the course of each other (Batum, 2008; Jackson & Jovev, 2006; Lilenfeld et al., 2006; Sansone & Levitt, 2005; Sansone & Levitt, 2006). For instance, the presence of eating disorders affects the course of borderline personality disorder which in return has interactive effects on the course of eating disorders (Sansone & Levitt, 2005; Sansone & Levitt, 2006). Indeed, in the review presented by Lilenfeld et al., (2006), the presence of Cluster B personality disorders and/or obsessive-compulsive personality disorder have been associated with poorer whereas histrionic personality traits and self-directedness have been linked with more favorable course and/or outcome.

E. The Aim of the Present Study and Specific Hypotheses

The main purpose of the present study was to investigate the prevalence of borderline personality disorder among eating disorders. Also, in the light of assumptions of the predispositional model, the relationship between borderline features and the likelihood of developing unhealthy eating attitudes and behaviors was also explored. Moreover, several socio-demographical and clinical variables that are thought to be associated with the relationship of borderline personality features and eating attitudes and behaviors were examined in order to bring a deeper understanding. Hence, the hypotheses of the current study are as follows;

1. The patients diagnosed with eating disorders are expected to be more likely to score above the cut-off point of Borderline Personality Inventory (BPI>20) and to be more likely to meet the criteria for borderline personality disorder, compared to the patients in both control groups. In other words, the prevalence of borderline personality disorder is expected to be higher in the group which includes patients diagnosed with eating disorders, than the Axis-I patients group and/or university students.
2. The bulimia nervosa (BN) group is expected to score higher in BPI than the binge-eating disorder group (BED) and the anorexia nervosa group (AN) respectively.
3. Unhealthy eating attitudes and behaviors are expected to increase as a function of borderline features displayed by the participants. In other words, it is expected that as the BPI scores increase, the EAT-40 scores also increases.
4. The patients in eating disorders group are expected to score higher on EAT-40 than the Axis-I disorder group and the university student group.

5. Female participants are expected to score higher in EAT-40, displaying higher levels of unhealthy eating attitudes and behaviors than male participants.
6. The EAT-40 scores are not expected to differ according to participants' socio-economic level.

Method

Participants

A total of 90 individuals participated in the present study, divided into 3 main groups:

Group 1: The patients who have applied to The Eating Disorder Clinic of The German Hospital and diagnosed with an eating disorder. All of these participants were evaluated by a psychiatrist and a clinical psychologist according to Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) and International Classification of Diseases and Related Health Problems (ICD-10; WHO, 1992) criteria. After this evaluation process, the participants who were diagnosed with eating disorders (bulimia nervosa, anorexia nervosa, and binge-eating disorder) were selected for the study, and the atypical cases (mixed types and eating disorders not otherwise specified; EDNOS) were excluded. Another psychiatrist's professional opinion was not required as there have been no disagreements regarding patients' diagnosis.

Group 2: The patients who have applied to The German Hospital, and diagnosed with any other Axis-I disorder were used as a control group for the study. The psychiatric evaluation process was exactly the same as the eating disordered group.

Group 3: The university students who were studying in a private university in Istanbul were selected as another control group for the study.

For validity purposes, the participants in both control groups who received a score higher than the cut-off score (+30) in The Eating Attitudes Test (EAT-40) were excluded from the study.

The sample included 65 female participants (72%) and 25 male participants (28%) with a mean age of 26. The detailed descriptives are presented in Table 1.

Table 1

The Mean, Minimum, Maximum, and Standard Deviation of Participants' Age according to Gender

	ED patients				University students				Ax-I Patients			
	N	Mean	Min.-Max.	SD	N	Mean	Min.-Max.	SD	N	Mean	Min.-Max.	SD
Female	28	27	18-48	7	11	21	20-24	1	26	29	18-45	6
Male	2	20	19-23	3	19	23	19-28	2	4	32	27-40	5

The majority of the participants (n=54, 60%) were born in Istanbul and 77 participants (85%) were living in the big cities for the last 5 years. Moreover, 37 participants (41%) were currently working, 33 (36%) were students, 11 (12%) were not working, and 7 (8%) were working and studying at the same time. 68 participants (75%) perceived themselves as successful students and 63 (70%) of them reported that they have had no missing year of education. The participants' level of education is presented in Table 2.

Table 2

The Frequencies and Percentages of Participants' Level of Education

	ED patients	University students	Ax-I patients	Total	Total %
Primary school	1	0	5	6	7%
High school	6	27	5	38	42%
Higher education	23	3	20	46	51%

Regarding socio-economic status, 65 participants (72%) perceived themselves as middle, 20 (22%) as high, and 5 (6%) as low. The majority of the participants (n=55, 61 %) were living with their family, and 14 (15%) were living alone. As for marital status, 74 participants (82%) were single, 12 (13%) were married, and 4 (4%) were divorced. The majority of the participants' parents (n=79, 87%) were married, 8 (9%) were divorced, and 3 (3%) were still married but living in different houses. 61 participants (68%) perceived their parents' socio-economic level as middle, 27 (30%) as high, and 2 (2%) as low. Regarding the level of education, 32 mothers (36%) had received higher education, 30 (33%) primary education, 26 (29%) high school education, and 2 (2%) had no history of education. On the other hand, 48 fathers (54%) had received higher education, 23 (26%) primary education, and 17 (19%) high school education. Moreover, the majority of the mothers were declared as unemployed at the moment, 47 (52%) were housewives and 29 (32%) were retired. 12 mothers (13%) were self-employed and 2 (2%) were government employees. The majority of the fathers (n=57, 63%) were self-employed, 26 (29%) were retired, 5 (6%) were government employees, and 2 (2%) were blue-collar workers.

Instruments

The socio-demographic form, the clinical information form, the Eating Attitudes Test and the Borderline Personality Inventory were administered respectively. In addition, all participants signed a consent form before entering the study and were informed about the aim of the study, namely, that the research aimed to investigate the possible relationship of eating disorders and personality (Appendix H). Moreover, they were assured of anonymity and confidentiality, and were asked to complete the questionnaires as honestly and as carefully as possible.

The Socio-Demographical Information Form

This form primarily aimed to gather basic socio-demographic information with questions regarding gender, age, place of birth, marital status, education, longest inhabited place, status of current accommodation, the parents' level of education, and employment status (Appendix I).

The Clinical Information Form

The form consisted of questions investigating specific indicators which are thought to be related to eating attitudes and behaviors such as weight checking, dieting, bingeing, compensatory behaviors, body image issues, use of pills to control weight, exercising and use of cigarette, alcohol and drugs. (Appendix J).

The Eating Attitudes Test-40 (EAT-40)

The Eating Attitudes Test (Appendix K) was developed by Garner and Garfinkel (1979) as a self-report measure of characteristic eating attitudes and behaviors of the individuals. The very first Turkish translation of the original test was completed in 1985 by Doğan, and in 1989, Savaşır and Erol retranslated the Eating Attitudes Test and also investigated the psychometric properties of the test.

The Eating Attitudes Test includes 40 items and the items are presented in a 6-point Likert scale including 'always', 'very often', 'often', 'sometimes', 'rarely', or 'never'. For questions 1, 18, 19, 23 and 39, the *extreme* (Savaşır & Erol, 1989, pp.19) ratings (always, very often, and often) were given '0' points whereas *non-extreme* ratings (never, rarely, and sometimes) representing pathology were weighted as 3, 2 points and 1 point respectively. For the rest of the questions, *non-extreme* ratings (never, rarely, and sometimes) were given '0' points whereas *extreme* ratings (always, very often, and often) were weighted as 3, 2 points and 1 point respectively (Savaşır & Erol, 1989). According to this rating system, the answers that do not represent any clinical significance are given no score at all.

The total score for abnormal eating attitudes and behaviors is calculated by the sum of the scores assigned to each item. The cut-off score for abnormal eating attitudes and behaviors is reported to be +30. The reliability and validity study of the Turkish version of the test report the alpha coefficients for anorexic patients as .65, and the total alpha coefficient for anorexic patients and the control as .70 (Savaşır & Erol, 1979).

The Borderline Personality Inventory

The Borderline Personality Inventory (Appendix L) was developed by Leichsenring (1999) as a self-report instrument assessing borderline personality organization and borderline personality disorder. Moreover, it was recommended for dimensional research of borderline features in Axis-I and Axis-II disorders and for evaluating the intensity of borderline personality symptoms. As Leichsenring (1999) stressed, this inventory is capable of identifying borderline patients in high agreement with Kernberg's definition of borderline personality organization, Gunderson's criteria for borderline personality disorder, and diagnostic criterions of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2001). The Borderline Personality Inventory consists of 53 items to assess identity diffusion, primitive defense mechanisms and reality testing and also fear of closeness (fear of fusion), and evaluates the participants by true/false (yes/no) answers (Leichsenring, 1999; Aydemir, Demet, Danacı, Deveci, Taşkın, & Mızrak, 2003). The total score of the test is calculated by the sum of 'true' responses.

The Turkish translation and reliability/validity study of the Borderline Personality Inventory was completed in 2003 (Aydemir et al.). Later, the study was repeated with an increased sample size (Aydemir, Demet, Danacı, Deveci, Taşkın, & Mızrak, 2006). The reliability analyses of this research have indicated that the Cronbach alpha coefficient calculated for the whole group was .92, and for the borderline personality disorders group it was .84. Also test-retest correlation was found to be statistically significant ($r=.67$, $p<0.005$).

In validity analyses, the cut-off point was found to be 15/16 with a sensitivity of 80.0% and specificity of 79.3%. The cut-off score obtained from the Turkish version of the inventory showed a slight difference from the original cut-off point +20. However, still, the Borderline Personality Inventory was found to be discriminating the borderline personality disorder group from other psychiatric disorder groups and from the healthy control group well.

Results

The total scores obtained from the EAT-40 are demonstrated in Table 3.

Table 3

The Minimum and Maximum, Means, and Standard Deviations of EAT-40 Scores

	Groups	N	Min.	Max.	Mean	SD
EAT-40	AN subgroup	9	19	74	46.3	17.3
	BN subgroup	12	11	64	41.9	17.2
	BED subgroup	9	15	46	26.8	10.8
	Overall ED group	30	11	74	38.1	17.1
	University students	30	5	29	13.5	6.1
	Axis-I patients	30	2	26	13.0	5.5
	Total	90	2	74	22	16.2

The total scores obtained from the BPI are presented in Table 4.

Table 4

The Minimum and Maximum, Means, and Standard Deviations of BPI Scores

	Groups	N	Min.	Max.	Mean	SD
BPI	AN subgroup	9	3	23	14.6	6.0
	BN subgroup	12	8	33	20.8	7.1
	BED subgroup	9	6	28	16.6	7.5
	Overall ED group	30	3	33	17.4	7.1
	University students	30	1	27	13.4	8.1
	Axis-I patients	30	1	36	14.1	9.2
	Total	90	1	36	15	8.2

Hypothesis 1: The patients diagnosed with eating disorders are expected to be more likely to score above the cut-off point of BPI (BPI>20) and to be more likely to meet the criteria for borderline personality disorder, compared to the patients in both control groups. In other words, the prevalence of borderline personality disorder is expected to be higher in the group which includes patients diagnosed with eating disorders, than the Axis-I patients group and/or university students.

Regarding the prevalence of borderline personality disorder among eating disorders, the Chi Square results demonstrated that the prevalence of borderline personality disorder did not differ among eating disorder groups and control groups [$\chi^2(4, 90) = 3.7, p > .05$]. Still, it was observed that 28.7% of the eating disorder patients met the criteria for borderline personality disorder (BPI score > 20) compared to 20% of Axis-I patients. In addition, 41.5% of the patients diagnosed with bulimia nervosa, 11.1% of anorexia nervosa and 33.3% of binge-eating disorder scored higher than the cut-off point of Borderline Personality Inventory

and accordingly met the criteria for borderline personality disorder. The prevalence of borderline personality disorder among all groups of eating disorders is displayed in Table 5.

Table 5

The Prevalence of Borderline Personality Disorder in the Eating Disorder Groups

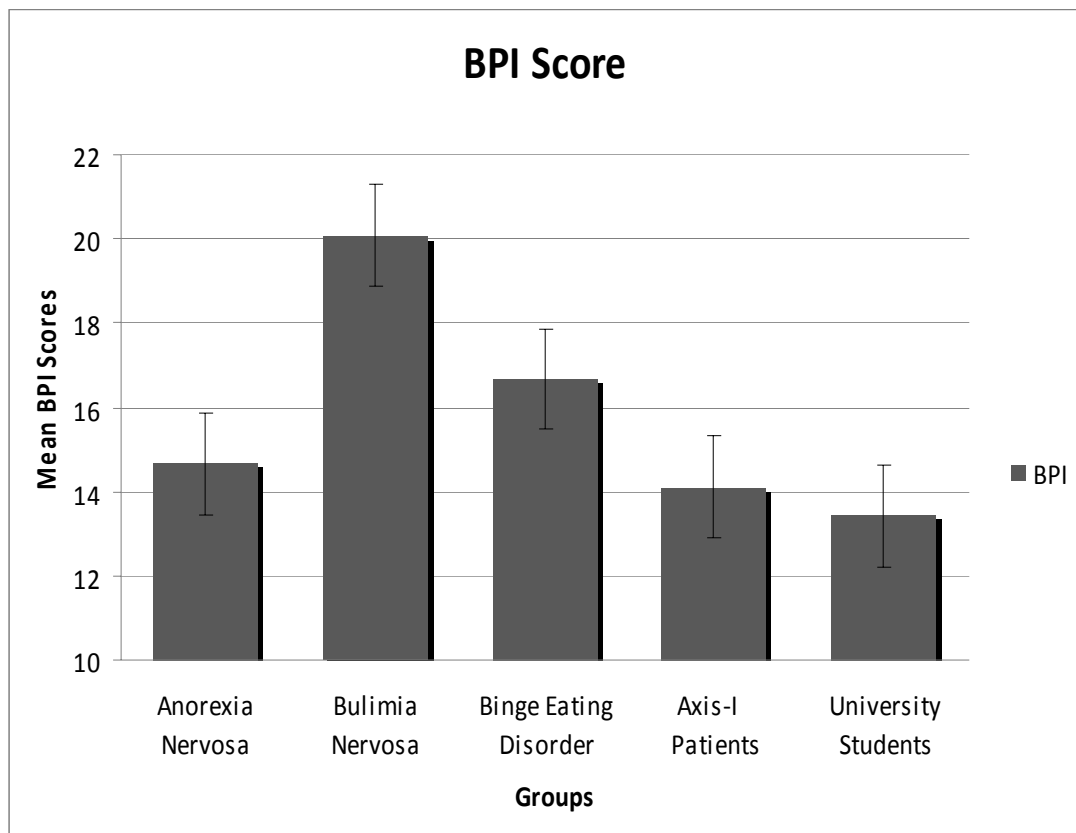
Groups	N	N of	
		BPD	%
AN subgroup	9	1	11.1
BN subgroup	12	5	41.7
BED subgroup	9	3	33.3
Overall ED group	30	9	28.7
University students	30	8	26.6
Axis-I patients	30	6	20
Total	90	23	25.4

* $\chi^2(4, 90) = 3.7, p > .05$

Hypothesis 2: The bulimia nervosa (BN) group is expected to score higher in BPI than the binge-eating disorder (BED) group and the anorexia nervosa (AN) group respectively.

According to the results of ANOVA, there is no significant difference in BPI scores as a function of group [$F(2, 87) = 2.05, p > .05$]. The distribution of BPI scores among subgroups of eating disorders and control groups is presented in Figure 1.

Figure 1. The distribution of mean of BPI scores according to the different eating disorder sub-groups

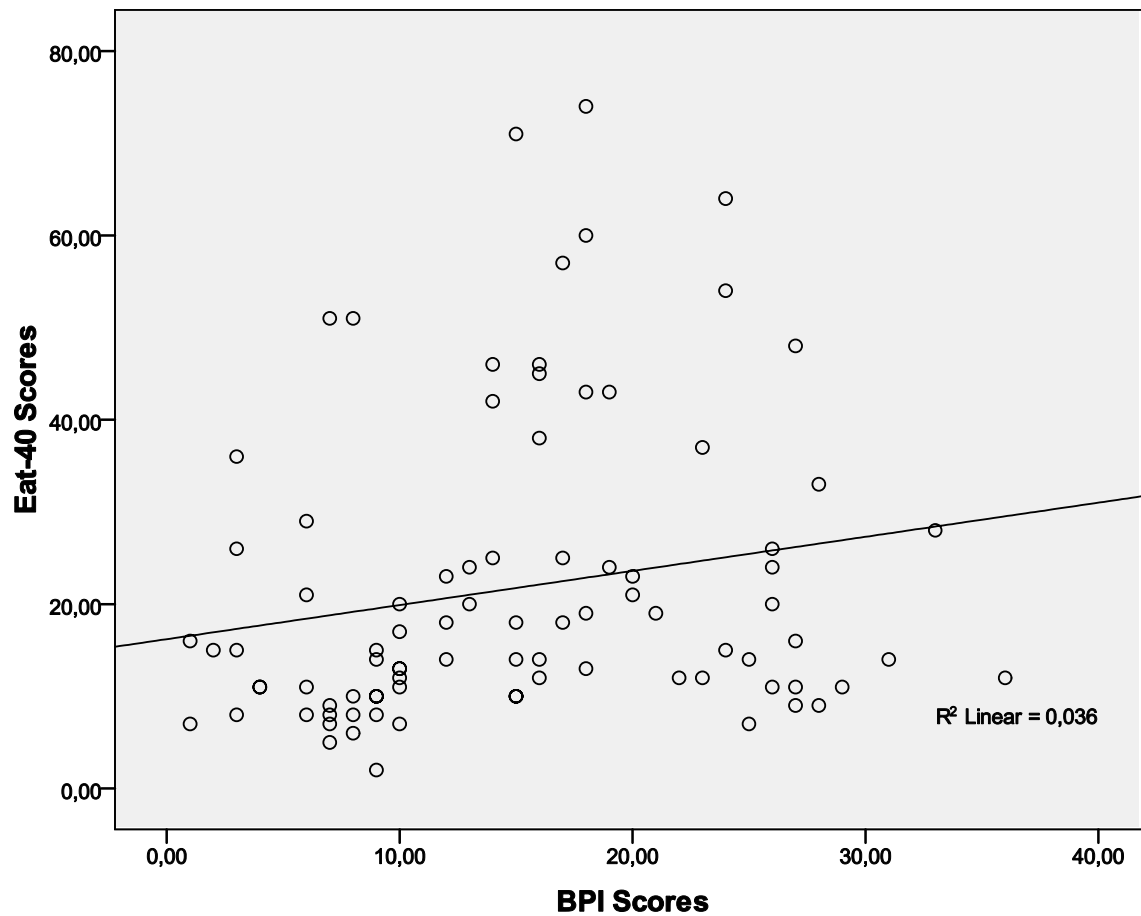


*Error bars represent standard error of the mean

Hypothesis 3: Unhealthy eating attitudes and behaviors are expected to increase as a function of borderline features displayed by the participants. It is expected that the participants' EAT-40 scores will be predicted by their BPI scores.

The regression analysis results demonstrated a significant relationship between borderline features and unhealthy eating attitudes and behaviors, $\beta = .250$, $t(4.3) = 12.9$, $p < .01$, once the anorexia nervosa group was excluded from the analysis. The BPI scores also explained a small yet significant proportion of the variance in EAT-40 scores, $R^2 = .062$, $F(1, 80) = 5.25$, $p < .01$. An illustration of the variance in EAT-40 as a function of BPI scores is presented in Figure 2.

Figure 2. The distribution of EAT-40 scores as a function of BPI scores

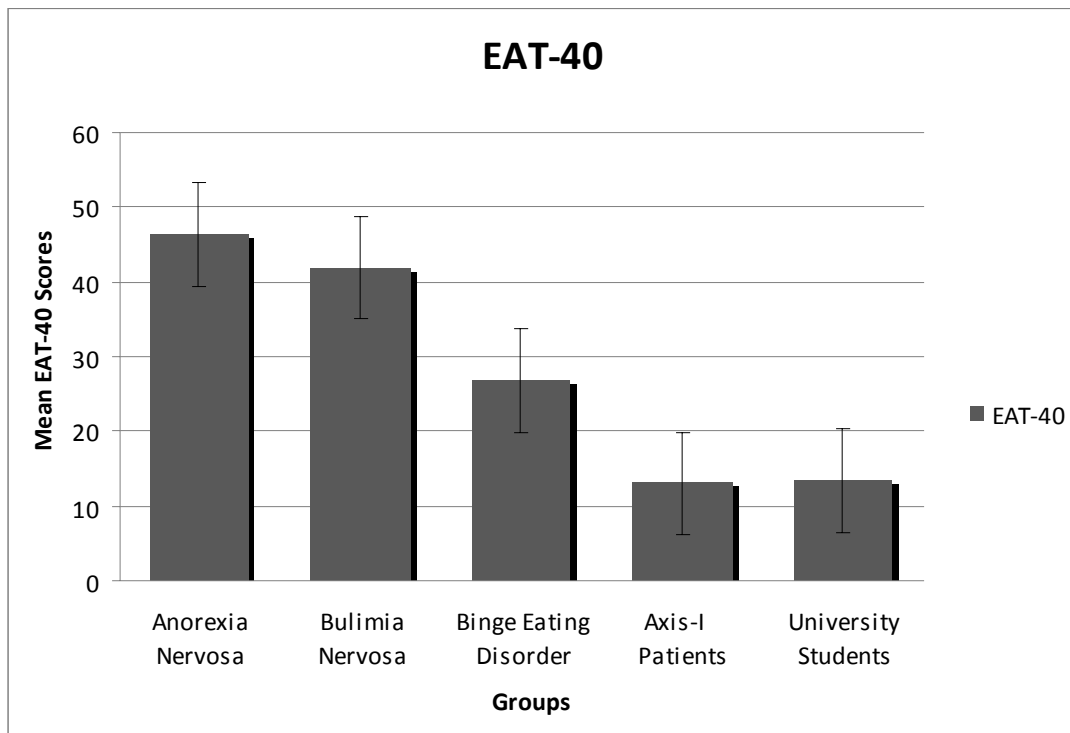


*Error bars represent standard error of the mean

Hypothesis 4: The patients in eating disorders group are expected to score higher on EAT-40 compared to the Axis-I disorder group and the university student group.

The result of ANOVA for EAT-40 scores indicated a significant difference on groups [$F(2, 87) = 53.7, p < .001$]. Moreover, the Post Hoc analysis using LSD yielded a significant difference between; (a) eating disorder group and university students group ($p < .01$) and (b) eating disorder group and Axis-I disorder group ($p < .001$). On the other hand, university students and Axis-I patients did not differ significantly on EAT-40 scores ($p > .05$). The detailed illustration of EAT-40 scores is presented in Figure 3.

Figure 3. The distribution of EAT-40 scores according to group



*Error bars represent standard error of the mean

Hypothesis 5: Female participants are expected to score higher in EAT-40, displaying higher levels of unhealthy eating attitudes and behaviors than male participants.

It was observed that female participants received higher scores on both EAT-40 and BPI than male participants. The means and standard deviations of EAT-40 and BPI scores for each gender are presented in Table 6.

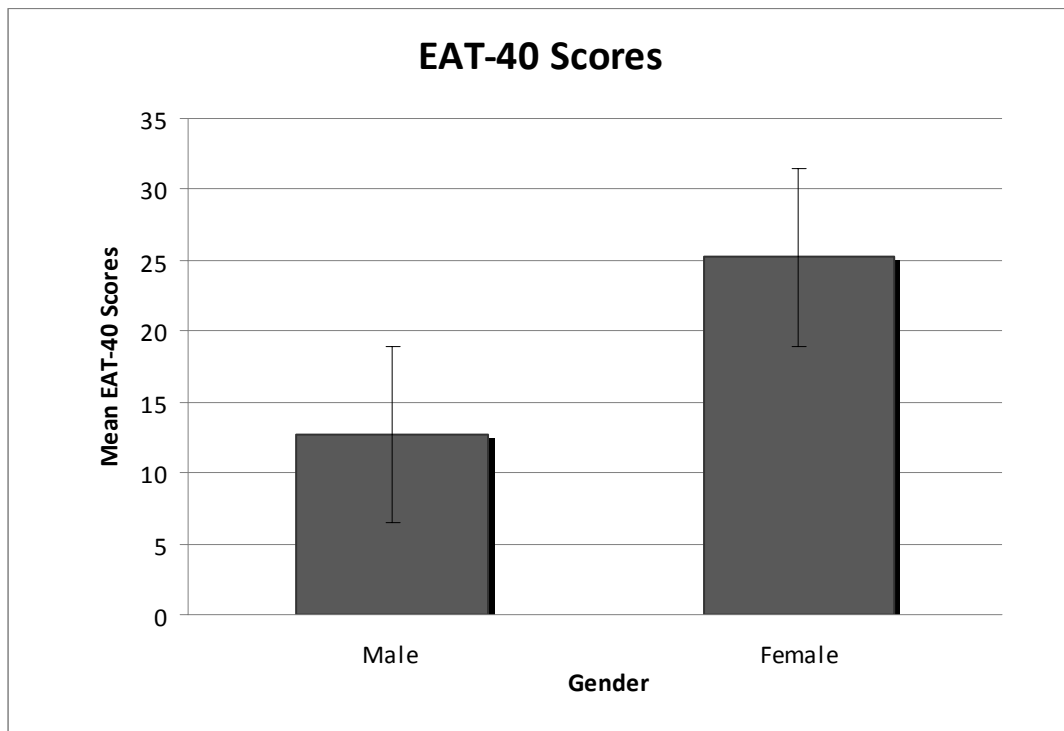
Table 6

The Means and Standard Deviations of EAT-40 and BPI Scores as a function of Gender

	Gender	N	Mean	SD
EAT-40	Male	25	12.7	4.1
	Female	65	25.2	17.7
BPI	Male	25	14.6	8.5
	Female	65	15.1	8.3

The independent sample t-test results revealed that there was a significant effect for gender [$t(88) = 3.5, p < .001$], with female participants receiving significantly higher scores in EAT-40, displaying higher levels of unhealthy eating attitudes and behaviors than male participants. On the other hand, according to the independent t-test results, gender was not found to be a statistically significant factor for BPI scores. The gender difference in EAT-40 is shown in Figure 4.

Figure 4. The distribution of EAT-40 scores as a function of gender.

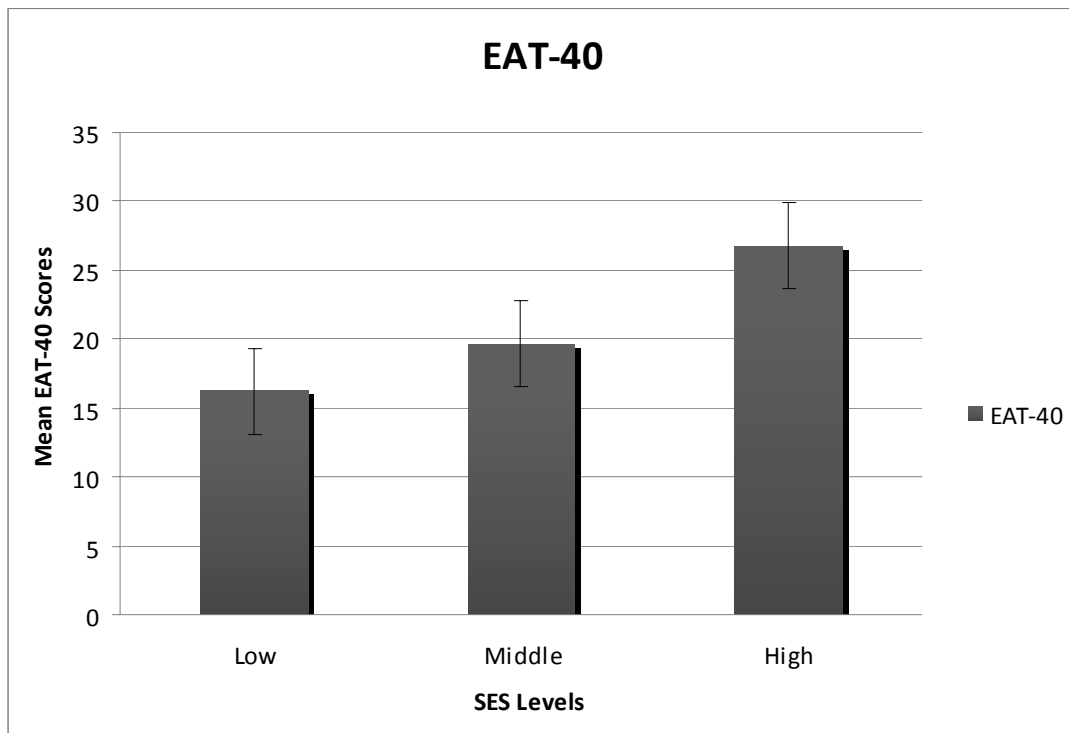


*Error bars represent standard error of the mean

Hypothesis 6: The EAT-40 scores are not expected to differ according to participants' socio-economic level.

The results of ANOVA demonstrated a significant difference in EAT-40 scores as a function of participants' socio-economic status [$F(2, 87) = 3.9, p < .005$]. The Post Hoc analysis using LSD yielded a significant difference between middle and high socio-economic status ($p < .01$). The low SES group excluded from Post Hoc analysis because of small sample size ($N=5$). The difference as a function of SES levels regarding EAT-40 scores is demonstrated in Figure 5.

Figure 5. The distribution of EAT-40 scores as a function of SES.



*Error bars represent standard error of the mean

There were also additional exploratory analyses. It was observed that 40 participants (45%) reported consuming alcohol. Among these participants, 26 (29%) stated that they used alcohol once every 3 day to everyday, 21 (24%) declared that the amount of alcohol taken in a day varied between 1 to 2 glasses, 9 (10%) up to 3 glasses, and 8 (9%) more than 3 glasses. The results of the independent samples t-test showed that alcohol users displayed significantly higher levels of borderline features [$t(88) = 2.5, p < .05$] than non-users. A second independent samples t-test revealed that binge-eaters exhibited significantly higher levels of borderline features [$t(88) = 2.12, p < .05$] than participants who did not binge. Finally, 35 participants (39%) reported night eating habits, and an independent samples t-test showed a statistically significant effect for night eating [$t(88) = 1.09, p < .005$], with night eaters scoring higher on BPI, and thus, representing higher levels of borderline features.

Discussion

The primary aim of the current study was to determine the prevalence of borderline personality disorder among patients diagnosed with eating disorders. As an introduction to the current study, an overview of the history of the borderline personality was presented, followed by a discussion of the theoretical and empirical arguments for the relationship between the two types of disorders. A set of hypotheses concerning this relationship were tested. Moreover, several dimensions that were thought to be explaining the possible relationship between borderline features and unhealthy eating attitudes and behaviors were investigated.

It was initially hypothesized that the prevalence of borderline personality disorder was expected to be higher among the group of eating disorders compared to the control groups. The analyses failed to support this hypothesis for the eating disorder group as a whole. This insignificant result is possibly due to the low number of borderline personality disorder diagnosis in anorexia nervosa subgroup compared to the other subgroups of eating disorders. Moreover, the bulimia nervosa group was hypothesized to score higher in BPI than the binge-eating disorder group and the anorexia nervosa group respectively. In fact, the analyses failed to support this hypothesis as there was no significant difference in borderline personality disorder scores as a function of group. As mentioned above, the context of the results indicated that anorexia nervosa group could not be evaluated as a standard subgroup as there was an elevated variance within the group, meaning some anorexia nervosa patients displayed high borderline features whereas others displayed none. As the least borderline personality loaded and the most eating disorder loaded group, anorexia nervosa subgroup was thought to be different than other groups of eating disorders.

In the light of this differentiation and as the group least loaded with borderline personality disorder, anorexia nervosa group was excluded from the sample, and thereafter, the results of the current study demonstrated borderline features predicted and explained a

small yet significant portion of variance in unhealthy eating attitudes and behaviors. This finding was important as a partial support of the hypothesis expecting unhealthy eating attitudes and behaviors to increase as a function of borderline features.

This finding was understandable since the subtypes of anorexia nervosa are considerably different from one another. In fact, in previous research, binge-eating/purging type of anorexia nervosa was predominantly associated with borderline personality (all cited in Dennis & Sansone, 1997).

Moreover, even though anorexia nervosa and bulimia nervosa were grouped under the same title of pathology, their etiology differs considerably. The literature has pointed out a relationship between anorexia nervosa and obsessive-compulsive personality, in connection with perfectionism (Dennis & Sansone, 1997; Favaro & Santonastaso, 2006; Maranon et al., 2004; Ro et al., 2005; Sansone et al., 2005; Wonderlich, 2002) whereas for bulimia nervosa, the relationship was bound to dramatic-erratic (Cluster B) personality disorders, and especially borderline personality, in connection with impulsivity (Abbott et al., 2001; Dennis & Sansone, 1991; Dennis & Sansone, 1997; Matsunaga et al., 1998; Ro et al., 2005; Sansone et al., 2005; Shipton, 2004; Wonderlich, 2002; Wonderlich & Swift, 1990). Moreover, it was stated that bulimia nervosa patients are more likely than anorexia nervosa patients to fit the description of borderline personality disorder (Shipton, 2004).

Nevertheless, 28.7% of eating disorder patients met the criteria for borderline personality disorder. This finding was consistent with the comorbidity ranges given in the literature (Bemporad et al., 1992; Godt, 2002; Godt, 2008; Maranon et al., 2004; Matsunaga et al., 1998; Ro et al., 2005; Sansone & Levitt, 2005; Sansone et al., 2005; Wonderlich & Mitchell, 2001).

In addition, 41.7 % of the bulimia nervosa patients fulfilled the criteria for borderline personality, with the highest percentage. Consistent with the conclusion of Sansone et al.,

(2005), bulimia nervosa appeared to be the most personality pathology loaded group among eating disorders. Also, several studies concluded that borderline personality disorder is more prevalent in individuals suffering from bulimia nervosa (Dennis & Sansone, 1997; Matsunaga, 1998; Ro et al., 2005; Sansone et al., 2005; Sansone et al., 1989) Indeed, Sansone et al., (1989) pointed four major former researches which have especially studied the prevalence of borderline personality among those with bulimia nervosa.

The prevalence rate of 41.7% for bulimia nervosa was consistent with the findings of several studies in which prevalence rates were ranging from 35% to 44% (Bulik et al., 1995, as cited in Cassin & von Ranson, 2005; Gwirstman, Roy-Bryne, Yager, & Gerner, 1983; as cited in Sansone et al., 1989; Inceoglu et al., 2000; Johnson, Tobin, & Enright, 1989; as cited in Sansone et al., 1989; Ristvedt et al., 1996, as cited in Cassin & von Ranson, 2005). On the other hand, Dennis & Sansone (1997) declared prevalence rates ranging from 1.9% to 75%, with an average of 34%, stressing the wideness of and discrepancy among findings. While several studies stated quite lower prevalence rates such as 28% (Sansone et al., 2005) and 30% (Ro et al., 2005) it is possible to find much lower prevalence rates in the literature (Berkman et al., 2007; Godt, 2002; Godt, 2008; Fichter, Quadflieg, & Hedlung, 2008; Maranon et al., 2004; Matsunaga et al., 1998; Pope, Frankenberg, Hudson, Jonas, & Yurgelun-Todd, 1987; as cited in Sansone et al., 1989; Wonderlich, Swift, Slotnick, & Goodman, 1990). For example, the research by Sansone et al., (1989) aimed to assess the borderline symptomology in bulimic patients; participants were administered three different borderline assessments and it was found that 39% of the bulimic were classified as borderline according to at least one measure, 29% according to two measures, and 18% according to all three measures.

The comorbidity of borderline personality disorder and bulimia nervosa has been frequently explained by self-destructiveness, (Abbott et al., 2001; Dennis & Sansone, 1997; Favaro & Santonastaso, 2006; Hsu, 1990; Kernberg, 1995; Sansone et al., 2005; Wonderlich

2002; Wonderlich & Swift, 1990), impulsivity and affective instability (Abbott et al., 2001; Favaro & Santonastaso, 2006; Sansone et al., 2005; Sansone & Levitt, 2005; Sansone & Levitt, 2006) as well as conflictual family structures (reviewed in Dennis & Sansone, 1991). In addition, it is known that individuals with bulimia nervosa display higher levels of impulsivity as exemplified in the behaviors of binge eating and purging. Shipton (2004, p.54-55) described some features of patients suffering from bulimia nervosa that seems highly associated with borderline personality as *'unstable and intense personal relationships, self-damaging impulsivity, emotional instability, inappropriate and intense anger, (...), and chronic feelings of emptiness or boredom'*.

Moreover, 33.3% of the binge-eating disorder group fulfilled the criteria for borderline personality disorder. Frankly, this prevalence rate appears to be considerably high compared with the literature. Sansone et al., (2005) reported the prevalence of borderline personality disorder among individuals with binge eating disorder at around 12%. Moreover, it is possible to find different prevalence rates ranges from 7% to 14 % in the literature (Berkman et al., 2007; Fichter et al., 2008; Telch & Stinice, 2008; Wilfley, Friedman, Dounchis, Stein, Welch, & Ball, 2000).

Finally 11.1% of patients diagnosed with anorexia nervosa suited the criteria for borderline personality disorder. The prevalence rates obtained from studies that used diagnostic reviews seem pretty low, ranging from 3% to 6% (Cassin & von Ronson, 2005; Matsunaga et al., 1998). On the other hand, the prevalence rates gathered from self-reports ranges from 17% to 60% (Cassin & von Ronson, 2005; Godt, 2001; Ro et al., 2005). In an article (Sansone et al., 2005) which also summarized the literature regarding prevalence of personality disorder among those with eating disorders, it appeared that a number of researches have divided anorexia nervosa into its subtypes as restricting and binge-eating purging anorexia nervosa, and reported that 10% of restricting anorexia nervosa and 28% of

binge-eating purging anorexia nervosa have received borderline diagnosis. Unfortunately, the present study did not make such differentiation. Nevertheless, these wide ranges regarding the prevalence of borderline personality might originate from the methodological differences in data collection as well as from the natural diversity that arises as a result of differentiation in subtypes of anorexia nervosa.

Moreover, the results demonstrated gender as a significant risk factor for unhealthy eating attitudes and behaviors. As hypothesized, the female participants scored significantly higher, displaying higher unhealthy eating attitudes and behaviors than male participants. Indeed, eating disorders appeared to be the most gender distinctive group among all psychiatric disorders. In the present study, the overwhelming majority (93%) of the patients diagnosed with eating disorders were female. This finding was perfectly compatible with the declared male-female percentages for eating disorders; 90-95 % females and 5-10% males (APA, 2006; Hoek, 2002; Hsu, 1990; PDM, 2006; Lucas et al., 1999; Reijonen et al., 2003).

Another expectation of the study was that socio-economic status (SES) would not make a difference in the amount of unhealthy eating attitudes and behaviors. The results failed to support this hypothesis. Unfortunately, in the current study, the number of low SES participants was too small for variance analyses. The participants ranked in the high SES level were found to display higher unhealthy eating attitudes and behaviors than participants ranked in the middle SES level. Even though, this finding was compatible with conventional Western literature (Polivy & Herman, 2002; Smith, 2008; Vandereycken, 2002; Vandereycken & Hoek, 1992), it contradicts with the recent literature (Vandereycken & Hoek, 1992). It is also different from the findings of some Turkish studies (Demir et al., 1998; Gürdal, Mırsal, & Cığeroğlu, 1997; İzmir, Erman, & Canat, 1993; Yeşilbursa, İmre, Türkcan, & Uygur, 1992) that point to a lack of relationship between socio-economic status and eating disorders.

One reason for the low representation of low SES participants in this study has to do with the difficulty of reaching the medical system and getting professional help in Turkey. In fact, this was stated as a challenging factor for the low SES individuals. In countries where the social health systems function better, eating disorders are also prevalent in the low SES population (Vandereycken & Hoek, 1992). Still, the nature of the sample could also affect these results as the data were gathered from a private hospital, The Eating Disorders Clinic of Alman Hospital. However, the data of control groups were also collected from the Psychiatric Unit of the same hospital and from a private university.

Finally, the results demonstrated that binge-eaters, night-eaters and alcohol users presented significantly higher levels of borderline features. In previous research, several similarities of the binge eating disorder and the night eating syndrome have been defined such as they are both seen in overweight and obese individuals and they both experience considerable amount of emotional distress and feelings of loss of control (Allison, Grilo, Mashep, & Stunkard, 2005).

Additionally, a study found that 44% of the participants diagnosed with night eating syndrome also fulfilled binge eating disorder criteria (Stunkard et al., as cited in Napolitano, Head, Babyak, & Bluementhal, 2001). Also, the night eating syndrome has been characterized with the combination of night eating and bingeing rather than night eating alone (Napolitano et al., 2001).

It is known that borderline individuals present impulse difficulties, commonly expressed in self-destructive behavior and self-regulatory problems (APA, 2001; Dennis & Sansone, 1997; Sansone & Levitt, 2005). Hence, it makes sense to evaluate bingeing behavior and night eating as highly impulsive acts. Impulsivity is conceptualized as a trait rather than a state feature and defined as *'the presence of impulsive behavior (e.g., kleptomania, addictions...binge eating..) or emotions that lead to impulsive reactions such as fear or anger,*

which are difficult to resist and may be harmful to oneself or others' (Beck & Mak, 1995, as cited in Favaro & Santonastaso, 2006, p.44). Moreover, borderline patients have limited capacity to self-soothe and it has been suggested that bingeing behaviors could be used as a mechanism that often supports self-soothing (Dennis & Sansone, 1997) as well as night eating. Also, regarding sense of control, it is known that individuals with borderline personality suffer from sense of loss of control, which could be triggered with both bingeing and night eating habits. Finally, the relation of alcohol and borderline features could be evaluated through impulsivity. The difficulties regarding impulse control could be expressed via self-regulation problems that may manifest themselves as alcohol abuse (APA, 2006; Dennis & Sansone, 1997; Welch & Fairburn, 1996 as cited in Favaro & Santonastaso, 2006).

Conclusion

The current study focused on the prevalence of borderline personality disorder among patients diagnosed with eating disorders, a topic which has not previously been studied in Turkey; also, several variables that were thought to be affecting the possible relationship between borderline features and unhealthy eating attitudes and behaviors were investigated.

The research design is fairly powerful as it included the study group of eating disorder patients and two other control groups. One control group was university students; the other control group was recruited from patients diagnosed with any other Axis-I disorder, in order to observe whether borderline personality is more common among those with eating disorders compared to individuals with other Axis-I diagnosis. As criticized by Batum (2008), very few studies compared eating disorders and other Axis-I disorders when studying comorbidity of personality disorders.

A major limitation of the study has to do with the sample. First of all, the sample size was too small. It was difficult to find a sufficient number of eating disorder patients as the

inclusion criteria were pretty limiting. Atypical and mixed types were excluded from the study to avoid any complications resulted from the mixed inner dynamics of the patients. As mentioned earlier, the majority of eating disorders patients tend to be diagnosed neither with anorexia nervosa nor with bulimia nervosa, but with eating disorders not otherwise specified as it requires no diagnostic criteria. Other researchers (Ro et al., 2005) have also complained that sometimes it is difficult to get large enough samples while conducting research on eating disorders.

Another limitation was that many patients, who have applied to The Eating Disorder Clinic of Alman Hospital were excluded from the study as they have not reached the recommended age for the borderline personality diagnosis. It is known that eating disorders patients are commonly pre-adolescences or adolescences. Therefore, eating disorder patients who were under the age of 18 and therefore below the age criteria for borderline personality diagnosis criteria were not able to participate in the study. Finally, the Psychiatric Unit of Alman Hospital is an outpatient psychiatric setting. Therefore both the eating disorder patients and Axis-I patients were outpatients. In literature, it has been speculated that inpatients suffer more from borderline personality than outpatients (Favaro & Santonastaso, 2006).

For future studies, my recommendation is to try to have equivalent numbers of participants in the different subgroups of eating disorders could be evenly distributed in order to conduct variance analyses. The research design can also be extended to include the subgroups of anorexia nervosa and bulimia nervosa as separate study groups. Finally, other specific Axis-I disorder groups could be included to observe different trends.

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Appendix A: The Diagnostic Criteria for Anorexia Nervosa According to the DSM-IV-TR.

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).*
- B. Intense fear of gaining weight or becoming fat, even though underweight.*
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.*
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)*

Specific types:

Restricting Type: *During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)*

Binge-eating/Purging Type: *During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).*

Appendix B: The Diagnostic Criteria for Anorexia Nervosa According to the ICD-10.

For a definite diagnosis of anorexia nervosa:

- (a) Body weight is maintained at least 15% below that expected (either lost or never achieved), or Quetelet's body-mass index is 17.5 or less. Prepubertal patients may show failure to make the expected weight gain during the period of growth.*
- (b) The weight loss is self-induced by avoidance of "fattening foods" and one or more of the following: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and/or diuretics.*
- (c) There is body-image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.*
- (d) A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis is manifest in women as amenorrhea and in men as a loss of sexual interest and potency. (An apparent exception is the persistence of vaginal bleeds in anorexic women who are receiving replacement hormonal therapy, most commonly taken as a contraceptive pill.) There may also be elevated levels of growth hormone, raised levels of cortisol, changes in the peripheral metabolism of the thyroid hormone, and abnormalities of insulin secretion.*
- (e) If onset is prepubertal, the sequence of pubertal events is delayed or even arrested (growth ceases; in girls the breasts do not develop and there is a primary amenorrhea; in boys the genitals remain juvenile). With recovery, puberty is often completed normally, but the menarche is late.*

Appendix C: The Diagnostic Criteria for Bulimia Nervosa According to the DSM-IV-TR.

- A. *Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:*
- 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances*
 - 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)*
- B. *Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.*
- C. *The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.*
- D. *Self-evaluation is unduly influenced by body shape and weight.*
- E. *The disturbance does not occur exclusively during episodes of Anorexia Nervosa.*

Specific types:

Purging Type: *During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas*

Non-purging Type: *During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.*

Appendix D: The Diagnostic Criteria for Anorexia Nervosa According to the ICD-10.

For a definite diagnosis of bulimia nervosa:

- (a) There is a persistent preoccupation with eating, and an irresistible craving for food; the patient succumbs to episodes of overeating in which large amounts of food are consumed in short periods of time.*
- (b) The patient attempts to counteract the "fattening" effects of food by one or more of the following: Self-induced vomiting; purgative abuse, alternating periods of starvation; use of drugs such as appetite suppressants, thyroid preparations or diuretics. When bulimia occurs in diabetic patients they may choose to neglect their insulin treatment.*
- (c) The psychopathology consists of a morbid dread of fatness and the patient sets herself or himself a sharply defined weight threshold, well below the premorbid weight that constitutes the optimum or healthy weight in the opinion of the physician. There is often, but not always, a history of an earlier episode of anorexia nervosa, the interval between the two disorders ranging from a few months to several years. This earlier episode may have been fully expressed, or may have assumed a minor cryptic form with a moderate loss of weight and/or a transient phase of amenorrhea.*

Appendix E: The Diagnostic Criteria for Binge Eating Disorder According to the DSM-IV-TR.

A. Recurring episodes of binge eating. The two characteristics of a binge eating episode are:

- 1. Eating a much larger amount of food than most people would consider normal under similar circumstances and within the same time frame (eating may continue for several hours).*
- 2. While eating, there is a feeling of loss of control over the amount of food or type of food being consumed.*

B. Binge eating episodes are related to at least three of the following:

- 1. Eating until feeling uncomfortably full.*
- 2. Eating large quantities of food when not even hungry.*
- 3. Eating noticeably faster than is considered normal.*
- 4. Eating alone due to embarrassment of overeating.*
- 5. Feelings of disgust, depression, or guilt after a binge.*

C. There is obvious distress concerning binge eating behavior.

D. On average, binge eating takes place twice weekly, and has done so for 6 months.

E. There are no recurring efforts to compensate for binge eating, such as purging or excessive exercise. The disorder occurs at times other than during episodes of anorexia nervosa or bulimia nervosa.

Appendix F: The Diagnostic Criteria for Borderline Personality Disorder According to the DSM-IV-TR.

Five out of nine criteria listed below are required as being present for a significant period of time;

- 1. Frantic efforts to avoid real or imagined abandonment (Not including suicidal or self-mutilating behavior covered in Criterion 5).*
- 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.*
- 3. Identity disturbance: markedly and persistently unstable self-image or sense of self.*
- 4. Impulsivity in at least two areas that are potentially self-damaging (e.g. promiscuous sex, eating disorders, binge eating, substance abuse, reckless driving) [Again, not including suicidal or self-mutilating behavior covered in Criterion 5].*
- 5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior such as cutting, interfering with the healing of scars (excoriation) or picking at oneself*
- 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).*
- 7. Chronic feelings of emptiness, worthlessness.*
- 8. Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).*
- 9. Transient, stress-related paranoid ideation, delusions or severe dissociative symptoms.*

Appendix G: The Diagnostic Criteria for Borderline Personality Disorder According to the ICD-10

1. *Impulsive type: The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behavior are common, particularly in response to criticism by others.*

Includes:

- * *explosive and aggressive personality (disorder)*

Excludes:

- * *dissocial personality disorder*

2. *Borderline type: Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).*

Includes:

- * *borderline personality (disorder)*

Appendix H: The consent form in Turkish

ARAŐTIRMA İZİN VE ONAY FORMU

'*Yeme Bozukluđu ve Kişilik*' adlı araştırmanın yeme tutum ve davranışları ve bir takım kişilik özellikleri arasındaki ilişkiyi anlama ihtiyacına yönelik düzenlendiđi düşünceyle; katılacağım araştırmanın ve sonuçlarının, bu tip çalışmalarda incelenmesi amacıyla kullanılmasına onay verir, sadece ve sadece bu amaçla kullanılmasında sakınca olmadığını beyan ederim.

Çalışma ile ilgili yazıyı okudum ve anladım.

Ad-Soyad :

Tarih :.../.../....

Uygulayan

Appendix I: The Socio-demographic Form in Turkish

SOSYO-DEMOGRAFİK BİLGİ FORMU

Aşağıdaki sorular, sosyo-demografik özellikleriniz ile ilgili bilgi toplamayı amaçlamaktadır.

Lütfen ifadeleri *dikkatle* okuyunuz ve size uygun olduğunu düşündüğünüz kutucuğu işaretleyiniz.

*Bu bilgiler sadece bu araştırma kapsamında kullanılacak ve gizli tutulacaktır.

1. Cinsiyetiniz Erkek Kadın
2. Yaşınız _____
3. Doğum yeriniz _____
4. En son bitirdiğiniz okul
 Öğrenimim yok İlköğretim Lise Yükseköğretim
5. Öğreniminiz süresince sene kaybınız var mı?
 Evet Hayır
6. Sizce başarılı bir öğrenci misiniz/ öğrenci miydiniz?
 Evet Hayır
7. Öğrenim/iş durumunuz (birden fazla seçenek işaretleyebilirsiniz)
 Çalışıyorum Çalışmıyorum Öğrenci Diğer
8. Medeni durumunuz
 Bekar Dul
 Evli Evli/ayrı evlerde
 Boşanmış Boşanmış/aynı evde
9. Aşağıdaki seçeneklerden hangisinin sizin sosyo-ekonomik durumunuzu daha iyi tanımladığını düşünüyorsunuz?
 Alt Orta Üst
10. Aşağıdaki seçeneklerden hangisinin ailenizin sosyo-ekonomik durumunu daha iyi tanımladığını düşünüyorsunuz?
 Alt Orta Üst
11. 0-7 yaş arasında, nasıl bir yerleşim alanında yaşadınız?
 Köy Kasaba Şehir Büyük şehir
12. Son 5 yıldır, nasıl bir yerleşim alanında yaşıyorsunuz?
 Köy Kasaba Şehir Büyük şehir
13. Şu an oturduğunuz ev
 Size ait Kiralık Lojman Diğer
14. Şu an oturduğunuz evde kendinize ait bir oda var mı?
 Evet Hayır
15. Anne-babanızın medeni durumu
 Evli Evli/ayrı evlerde
 Boşanmış Boşanmış/aynı evde

16.Şu an kiminle yaşıyorsunuz?

- Yalnız Ailemle beraber Annemle beraber
 Babamla beraber Sevgilimle beraber Diğer (belirtiniz.....)

17.0-7 yaş arasında, kim tarafından büyütüldünüz (birden fazla seçenek işaretleyebilirsiniz)?

- Annem Babam Bakıcı
 Büyükanne/Büyükbaba Diğer

18.Annenizin iş durumu

- Çalışmıyor Ev Hanımı Emekli
 Çalışıyor Serbest Memur İşçi

19.Annenizin öğrenim durumu

- Öğrenimi yok İlköğretim Lise Yükseköğretim

20.Anneniz hayatta mı?

- Evet Hayır

21.Babanızın iş durumu

- Çalışmıyor Emekli
 Çalışıyor Serbest Memur İşçi

22.Babanızın öğrenim durumu

- Öğrenimi yok İlköğretim Lise Yükseköğretim

23.Babanız hayatta mı?

- Evet Hayır

24.Kardeşiniz var mı?

Yok

- 1 Erkek/benden büyük Kız/ benden büyük Erkek/benden küçük Kız/ benden küçük
 2 Erkek/benden büyük Kız/ benden büyük Erkek/ benden küçük Kız/ benden küçük
 3 ve üstü Erkek/benden büyük Kız/ benden büyük Erkek/ benden küçük Kız/ benden küçük

25. Kardeşiniz varsa, doğum sırasına göre ailedeki kaçınıcı çocuğunuz?

- 1 2 3 4 ve üstü

26.Şu an romantik bir birlikteliğiniz/ ilişkiniz var mı?

- Evet Hayır

27.Bir önceki soruya cevabınız 'Hayır' ise, daha önce bir ilişkiniz oldu mu?

- Evet Hayır

28. Hiç cinsel birliktelik yaşadınız mı?

- Evet Hayır

29.Çocuğunuz var mı?

- Yok 1 2 3 ve üstü

Appendix J: The Clinical Information Form in Turkish

BİLGİ FORMU

Aşağıdaki anket, yeme alışkanlıklarınız ve bedeninizle ilgili bazı genel ve klinik sorulardan oluşmaktadır. Lütfen ifadeleri *dikkatle* okuyunuz ve size uygun olduğunu düşündüğünüz kutucuğu işaretleyiniz.

1.	Ne sıklıkta tartılırsınız?	<input type="checkbox"/> Günde en az 1	<input type="checkbox"/> Ayda 1'den daha seyrek	<input type="checkbox"/> Haftada 1-ayda 1 arası
		<input type="checkbox"/> Günde 1- haftada 1 arası	<input type="checkbox"/> Nadiren ya da hiç tartılmam	
2.	Ne sıklıkla diyet yaparsınız?	<input type="checkbox"/> Çok sık	<input type="checkbox"/> Oldukça sık	<input type="checkbox"/> Ara sıra
		<input type="checkbox"/> Nadiren	<input type="checkbox"/> Hiçbir zaman	
3.	Eğer daha önce diyet yaptıysanız, ilk diyet yaptığınızda kaç yaşındaydınız?	_____		
4.	Diyet yapma şekliniz nedir (birden fazla seçenek işaretleyebilirsiniz)?	<input type="checkbox"/> Öğün atlama	<input type="checkbox"/> Bütün gün yememe	<input type="checkbox"/> Yağlıları sınırlama
		<input type="checkbox"/> Tatlıları sınırlama	<input type="checkbox"/> Karbonhidratları sınırlama	<input type="checkbox"/> Porsiyon küçültme
		<input type="checkbox"/> Güncel diyet programları	<input type="checkbox"/> Diğer (belirtiniz.....)	
5.	Haftada kaç gün egzersiz/spor yapıyorsunuz?	<input type="checkbox"/> Hiç yapmıyorum.	<input type="checkbox"/> 1-2 gün	<input type="checkbox"/> 2-3 gün <input type="checkbox"/> 4 gün ve üstü
6.	<u>Bir önceki soruya cevabınız 'Evet' ise,</u> her seansınız yaklaşık kaç saat sürüyor?	<input type="checkbox"/> 1-2 saat	<input type="checkbox"/> 2-3 saat	<input type="checkbox"/> 3 saat ve üstü
7.	Sigara içiyor musunuz?	<input type="checkbox"/> Evet	<input type="checkbox"/> Hayır	
8.	<u>Bir önceki soruya cevabınız 'Evet' ise,</u> günde ne kadar sigara içiyorsunuz?	<input type="checkbox"/> 5-10 tane	<input type="checkbox"/> 10-20 tane	<input type="checkbox"/> 1 paket ve üstü
9.	Alkol kullanıyor musunuz?	<input type="checkbox"/> Evet	<input type="checkbox"/> Hayır	
10.	<u>Bir önceki soruya cevabınız 'Evet' ise,</u> haftada kaç gün alkol kullanıyorsunuz?	<input type="checkbox"/> 1-3 gün	<input type="checkbox"/> 3-5 gün	<input type="checkbox"/> 5 gün ve üstü
11.	<u>Alkol kullanıyorsanız,</u> bir günde aldığınız ortalama miktar nedir?	<input type="checkbox"/> 1-2 bardak	<input type="checkbox"/> 2-3 bardak	<input type="checkbox"/> 3 bardak ve üstü
12.	Madde (uyuşturucu, uyarıcı vb.) kullanıyor musunuz?	<input type="checkbox"/> Evet	<input type="checkbox"/> Hayır	
13.	<u>Bir önceki soruya cevabınız 'Evet' ise,</u> ne sıklıkta madde kullanıyorsunuz?	<input type="checkbox"/> Ayda bir	<input type="checkbox"/> İki haftada bir	<input type="checkbox"/> Haftada bir <input type="checkbox"/> Gün aşırı <input type="checkbox"/> Hergün
14.	Kilolu olduğunuzu düşünüyor musunuz?	<input type="checkbox"/> Evet	<input type="checkbox"/> Hayır	

15. Aynaya baktığınızda vücudunuzu beğeniyor musunuz?

- Evet Hayır

16. Kilo vermeyi düşünüyor musunuz?

- Evet Hayır

17. Kilo almaktan endişe duyuyor musunuz?

- Evet Hayır

18. Arkadaşlarınızdan ne sıklıkta dış görünümünüze ilişkin olumsuz eleştiriler alırsınız?

- Çok sık Oldukça sık Ara sıra
 Nadiren Hiçbir zaman

19. Hoşlandığınız/ birlikte olduğunuz kişi/lerden ne sıklıkta dış görünümünüze ilişkin olumsuz eleştiriler alırsınız?

- Çok sık Oldukça sık Ara sıra
 Nadiren Hiçbir zaman

20. Annenizden ne sıklıkta dış görünümünüze ilişkin olumsuz eleştiriler alırsınız?

- Çok sık Oldukça sık Ara sıra
 Nadiren Hiçbir zaman

21. Babanızdan ne sıklıkta dış görünümünüze ilişkin olumsuz eleştiriler alırsınız?

- Çok sık Oldukça sık Ara sıra
 Nadiren Hiçbir zaman

22. Çevrenizden gelen olumsuz eleştiriler nedeniyle, ne sıklıkla zayıflama girişiminde bulundunuz?

- Çok sık Oldukça sık Ara sıra
 Nadiren Hiçbir zaman

23. Evinizde yasaklı olan yiyecekler var mı?

- Evet Hayır

24. Gıda alerjiniz var mı?

- Evet Hayır

25. Düzenli kullandığınız bir ilaç var mı?

- Evet Hayır

26. Kronik bir ağrınız var mı?

- Evet Hayır

27. Düzenli adet görüyor musunuz (kadınlar için) ?

- Evet Hayır

28. Düzenli adet görmek için bir ilaç kullanıyor musunuz (kadınlar için)?

- Evet (belirtiniz.....) Hayır

29. Vücudunuzda normal olmayan bir tüylenme olduğunu düşünüyor musunuz?

- Evet Hayır

- Abur cubur Diğer (belirtiniz.....)

46. Gece yemek yemek için uykudan uyandıığınız olur mu? Evet Hayır

30. Diş sağlığıyla ilgili sorunlarınız var mı? Evet Hayır

47. Yemek sonrası yedikleriniz ağzınıza geliyor mu? Evet Hayır

31. Kilo ile ilgili (zayıflık ya da şişmanlık) için yardım aldınız mı? Evet Hayır

48. Hiç yemekten rahatsız olduğunuz için kustuğunuz ya da tükürdüğünüz oldu mu? Evet Hayır

32. Kilo kontrolü amacıyla ilaç kullandınız mı? Evet Hayır

- Evet Hayır

33. Bir önceki soruya cevabınız 'Evet' ise, ne tip bir ilaç kullandınız ? (birden fazla seçenek işaretleyebilirsiniz)

İdrar söktürücü ilaçlar Laksatifler (dışkılamaya yardımcı ilaçlar)

Diyet hapları Tiroid metabolizmasını hızlandırıcı ilaçlar

34. Daha önce 'Yeme Bozukluğu' tanısı aldınız mı ? **Eğer almadıysanız lütfen 44. soruya ilerleyiniz.**

Evet Hayır **Lütfen 44. soruya ilerleyiniz.**

35. Hastalığınızın başlangıcında diyet yapıyor muydunuz?

Evet Hayır

36. Hastalığınız başladığında kaç yaşındaydınız? _____

37. Hastalığınız ne kadar süredir devam ediyor? _____

38. Hastalığınızın başlangıcından ne kadar süre sonra tedavi için başvurduunuz? _____

39. Hastalığınız ilgili ilk hangi doktora gittiniz?

Dahiliye Kadın doğum uzmanı Psikiyat/ Psikolog

Diyetisyen Pratisyen Aile hekimi

Diğer (belirtiniz.....)

40. Bu problemle ilgili hastaneye yattınız mı?

Evet Hayır

41. Bir önceki soruya 'Evet' dediyseniz, yattığınız hastanenin türü nedir?

Özel hastane Devlet hastanesi Üniversite hastanesi

42. Eğer bir hastanede yattıysanız, ne kadar süre yattınız? _____

43. Yeme bozukluğu ile ilgili herhangi bir dahili (bedensel) rahatsızlığınız var mı?

Hayır Elektrolit dengesizliği (kan tuz dengesizliği, ör: potasyum dengesizliği)

Anemi (kansızlık) Osteoporoz (kemik erimesi)

44. Hiç tıkanırca yediğiniz oldu mu?

Evet Hayır

45. Bir önceki soruya cevabınız 'Evet' ise, en çok hangi tür gıdaları tüketirsiniz (birden fazla seçenek işaretleyebilirsiniz)

Ekmek, hamur işi Süt ve süt ürünleri

Et ürünleri Tatlılar

Meyveler Sebzeler

49. Kendinizi, bir şey kullanarak, kusturduğunuz oluyor mu?

- Evet Hayır

50. Aile içinde düzenli egzersiz/spor yapan biri/birileri var mı?

- Evet Hayır

51. Ailenizde akşam yemeği için belirgin bir saat var mı?

- Evet Hayır

52. Akşam yemeklerinde aileniz ile ne sıklıkta beraber sofraya oturursunuz?

- Çok sık Oldukça sık Ara sıra
 Nadiren Hiçbir zaman

53. Ailenizde tanı almış herhangi bir ruhsal hastalık var mı?

- Yok Depresyon Anksiyete
 Yeme bozukluğu Duygu-durum bozukluğu Obsesif-kompulsif bozukluk
 Kleptomani Alkol kötüye kullanımı Kendine zarar verme davranışları
 Uyku problemleri Madde kötüye kullanımı Diğer (belirtiniz.....)

Appendix L: The Borderline Personality Inventory in Turkish

18. Düşüncelerim başkaları tarafından okunuyor okunuyor gibi hissettiğim oldu.	DOĞRU	YANLIŞ
Aşağıda, kişilik özellikleri ile ilgili ifadeler bulunmaktadır.		
Lütfen ifadeleri <i>dikkatle</i> okuyunuz ve bu cümlelerden size uygun olanlarını işaretleyiniz.		
19. Bazen gerçekte suç işlemediğim halde, sanki işlemişim gibi suçluluk hissedirim.	DOĞRU	YANLIŞ
20. Bazen kendimi bedensel zarar verdiğim oldu.	DOĞRU	YANLIŞ
21. Bazen gerçekte olmadığı halde insanların ve nesnelere görünümünün	DOĞRU	YANLIŞ
2. Son zamanlarda beni duygusal olarak etkileyen hiç birşey olmadı.	DOĞRU	YANLIŞ
değiştiği hissine kapılıyorum.	DOĞRU	YANLIŞ
3. Çoğu kez gerçekte kim olduğumu merak ederim.	DOĞRU	YANLIŞ
22. Yoğun dini uğraşlarım olmuştur.	DOĞRU	YANLIŞ
23. Doğru ve yanlışlar arasında kararlar almam bir ilişki istediğimden emin	DOĞRU	YANLIŞ
olamam.	DOĞRU	YANLIŞ
5. Başkaları bana yoğun ilgi gösterdikleri zaman kendimi boğulmuş hissedirim.	DOĞRU	YANLIŞ
24. Bazen bir kahin gibi gelecekle ilgili özel hislerim olur.	DOĞRU	YANLIŞ
6. Bazen içimde bana ait olmayan başka bir kişi ortaya çıkar.	DOĞRU	YANLIŞ
25. Bir ilişki ilerledikçe kendimi kapana kısılmış gibi hissedirim.	DOĞRU	YANLIŞ
7. Gerçekte olmadığı halde acayip şekiller veya görüntüler gördüğüm oldu.	DOĞRU	YANLIŞ
26. Gerçekte kimse olmadığı halde bir başka insanın varlığını hissettiğim oldu.	DOĞRU	YANLIŞ
8. Bazen çevremdeki insanlar ve nesnelere gerçek olmadığını hissedirim.	DOĞRU	YANLIŞ
27. Bazen bedenim ya da bedenimin bir kısmı bana acayip veya değişmiş gibi	DOĞRU	YANLIŞ
9. Başkalarına yönelik duygularım bir uçtan bir uca çok hızla değişir (Or. Sevgi görünür ve beğeniden, nefret ve hayal kırıklığına).	DOĞRU	YANLIŞ
28. İlişkiler çok ilerlerse, çoğunlukla koparma gereksinimi duyarım.	DOĞRU	YANLIŞ
10. Çoğu kez değersizlik ya da umutsuzluk duygusuna kapılıyorum.	DOĞRU	YANLIŞ
29. Bazen birilerinin peşimde olduğu hissine kapılıyorum.	DOĞRU	YANLIŞ
11. Çoğu kez paramı çarçur ederim ya da kumarda kaybederim.	DOĞRU	YANLIŞ
30. Sık sık uyuşturucu kullanırım (esrar, hap gibi).	DOĞRU	YANLIŞ
12. Gerçekte kimse olmadığı halde hakkımda konuşan sesler duyduğum oldu.	DOĞRU	YANLIŞ
31. Başkalarını kontrol altında tutmaktan hoşlanırım.	DOĞRU	YANLIŞ
13. Eğer 12. maddeye 'Doğru' dediyseniz aşağıdaki cümlelerden sizin için doğru olanını seçiniz:	DOĞRU	YANLIŞ
32. Bazen, özel biri olduğumu hissedirim.	DOĞRU	YANLIŞ
a. Bu sesler benim dışarıdan gelmiştir.	DOĞRU	YANLIŞ
33. Bazen dağılıyormuş gibi hissedirim.	DOĞRU	YANLIŞ
b. Bu sesler benim içimden gelmiştir.	DOĞRU	YANLIŞ
34. Bazen bana bir şeyin gerçekte mi, yoksa yalnızca hayalimde mi olduğunu	DOĞRU	YANLIŞ
14. Yakın ilişkilerde hep incinirim.	DOĞRU	YANLIŞ
15. Bana transvançim duşun ettiğimde davet olduğum oldu.	DOĞRU	YANLIŞ
16. Bir kukla gibi dışarıdan yönetiliyormuş ve yönlendiriliyormuş gibi hissettiğim	DOĞRU	YANLIŞ
36. Bazen gerçek olmadığım duygusuna kapılıyorum.	DOĞRU	YANLIŞ
oldu.	DOĞRU	YANLIŞ
37. Bazen bedenim yokmuş ya da bir kısmı eksikmiş hissine kapılıyorum.	DOĞRU	YANLIŞ
17. Herhangi birine fiziksel olarak saldırıda bulunduğum oldu.	DOĞRU	YANLIŞ

38. Çoğu kez kabus görürüm. DOĞRU YANLIŞ
39. Çoğu kez başkaları bana gülüyormuş ya da hakkımda konuşuyormuş hissine kapılıyorum. DOĞRU YANLIŞ
40. Çoğu kez insanlar bana düşmanmış gibi gelir. DOĞRU YANLIŞ
41. İnsanların kendi düşüncelerini benim zihnime soktuklarını hissettiğim oldu. DOĞRU YANLIŞ
42. Çoğu kez gerçekten ne istediğimi bilmem. DOĞRU YANLIŞ
43. Geçmişte intihar girişiminde bulundum. DOĞRU YANLIŞ
44. Bazen ciddi bir hastalığım olduğuna inanırım. DOĞRU YANLIŞ
45. ‘Alkol, uyuşturucu ya da hap alışkanlığım vardır’.
Eğer yanıtınız ‘Evet’ ise aşağıdakilerden uygun olanlarını işaretleyiniz. DOĞRU YANLIŞ
- a. Alkol b. Uyuşturucu c. Hap
46. Bazen bir rüyada yaşıyormuş ya da yaşamım bir film şeridi gibi gözümün önünden geçiyormuş hissine kapılıyorum. DOĞRU YANLIŞ
47. Çoğu kez birşeyler çalarım. DOĞRU YANLIŞ
48. Bazen öyle açlık nöbetlerim olur ki önüme gelen her şeyi silip süpürürüm. DOĞRU YANLIŞ
49. Aşağıdaki konularla ilgili sorularda çoğu kez kendimi rahatsız hissederim. DOĞRU YANLIŞ
- a. Politika b. Din c. Ahlak (iyi-kötü)
50. Bazen aklımdan birilerini öldürme düşüncesi geçer. DOĞRU YANLIŞ
51. Yasalarla başımın derde girdiği oldu. DOĞRU YANLIŞ
52. Yukarıdaki maddelerle anılan yaşantılardan herhangi birini ilaç etkisi altında yaşadığınız oldu mu? Eğer yanıtınız ‘Evet’ ise ilgili maddelerin numaralarını yazınız: (.....) DOĞRU YANLIŞ
53. Yukarıdaki maddelerle anılan yaşantılardan herhangi birini psikoterapi sırasında yaşadığınız oldu mu? Eğer yanıtınız ‘Evet’ ise ilgili maddelerin numaralarını yazınız: DOĞRU YANLIŞ