DO BORDERLINE TRAITS MAKE PEOPLE MORE SENSITIVE? THE RELATIONSHIP BETWEEN BORDERLINE PERSONALITY TRAITS AND MENTALIZATION CAPACITY

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PLAGIARISM

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

14.06.23

Ayşe Kazaca

ABSTRACT

The literature on the relationship between borderline personality disorder (BPD) and Theory of Mind (ToM) has revealed mixed results. Studies generally indicate difficulties in mentalization abilities among individuals with BPD, but it is still unclear whether these difficulties stem from a deficit in mentalization (or ToM) or from excessive mentalization. This study therefore aimed to investigate the relationship between borderline personality traits, reflective functioning, and ToM. A total of 70 participants took part in the study. The age range of the participants was 19 to 58, with the majority falling into the young adult category. Borderline Personality Scale, Reflective Functioning Scale, Experiences in Close Relationships- II Scale, Beck Depression scale, and Faux Pas Task were utilized in data collection process. The results indicated that participants with high borderline traits displayed a greater tendency towards hypomentalization rather than hypermentalization. Additionally, participants with high borderline traits obtained lower scores in the Faux Pas Task. Furthermore, higher scores on BPS were related to higher levels of both attachment anxiety and attachment avoidance. No significant results were obtained with regard to age and gender. These findings are significant in enhancing our understanding of the relationship between borderline personality traits and mentalization.

Keywords: borderline personality disorder (BPD), mentalization, reflective function, Theory of mind (ToM), faux pas task

ÖZET

Borderline kişilik bozukluğu (BKB) ile Zihin Kuramı (ZK) arasındaki ilişki üzerine yapılan literatür, karışık sonuçlar ortaya koymuştur. Çalışmalar genellikle BKB'li bireylerde mentalizasyon yeteneklerinde zorluklar olduğunu göstermektedir, ancak bu zorlukların mentalizasyon eksikliğinden (veya ZK eksikliğinden) mi yoksa aşırı mentalizasyondan mı kaynaklandığı hala belirsizdir. Bu çalışma, bu nedenle borderline kişilik özellikleri, yansıtıcı işlevsellik ve ZK arasındaki ilişkiyi araştırmayı amaçlamıştır. Çalışmaya toplamda 70 katılımcı katılmıştır. Katılımcıların yaş aralığı 19 ila 58 arasında değişmekte olup, çoğunluk genç yetişkin kategorisine girmektedir. Veri toplama sürecinde Borderline Kişilik Ölçeği, Yansıtıcı İşlevsellik Ölçeği, Yakın İlişkilerde Deneyimler-II Ölçeği, Beck Depresyon Ölçeği ve Faux Pas Görevi kullanılmıştır. Sonuçlar, yüksek borderline özelliklere sahip katılımcıların hiper mentalizasyon yerine hipo-mentalizasyon eğilimi gösterdiklerini göstermiştir. Ayrıca, yüksek borderline özelliklere sahip katılımcıların Faux Pas Görevi'nde daha düşük puanlar aldığı belirlenmiştir. Bunun yanı sıra, BKB'deki yüksek puanlar, hem bağlanma kaygısı hem de bağlanma kaçınma düzeyleriyle ilişkili bulunmuştur. Yaş ve cinsiyetle ilgili anlamlı sonuçlar elde edilmemiştir. Bu bulgular, borderline kişilik özellikleri ile mentalizasyon arasındaki ilişkinin anlaşılmasına katkı sağlamaktadır.

Anahtar Kelimeler: sınır kişilik bozukluğu, mentalizasyon, yansıtıcı işleyiş, zihin kuramı, faux pas görevi,

To my family…

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1. INTRODUCTION

Borderline Personality Disorder (BPD) is a debilitating mental health condition that has been discussed and studied in the literature for a long time. Various theorists from the psychoanalytic perspective, as well as other areas like cognitive-behavioral therapy (CBT) and neuroscience, have tried to provide a comprehensive explanation for BPD. The term 'borderline personality' was first introduced by Stern (1938), and he conceptualized this term for patients who did not show any progress with standard psychoanalytic treatment (Bateman, 2011). Stern (1938) positioned the borderline group between the neurotic and psychotic groups. Schmideberg (1947) first conceptualized borderline personality disorder as a personality disorder characterized by rapid mood swings, distorted social functioning, a tendency to live a chaotic life, and being unsuitable for traditional psychoanalytical therapy due to lack of insight and the inability to free associate. Also, Kernberg (1967) stated that these patients neither fully fit into the psychotic nor the neurotic group; their ego strength is much better than psychotics, but ego functioning differs from the neurotic group. The psychodynamic literature has defined some of the primary key features of the borderline personality organization with its unintegrated identity structure, primitive defense mechanisms, incomplete formation of self-object boundaries, intact reality perception, severe affect instability, and self-destructive behaviors (McWilliams, 2020). Kernberg conceptualized borderline personality disorder with a psychoanalytical approach and benefited from Mahler's (1952) developmental stages. In line with this, borderline patients are thought to complete the symbiotic phase that is defined by Mahler, and accomplishment of this phase refers to self-object separation (Mahler et al., 1975). However, according to Kernberg (1975), these patients have some fixations in the rapprochement part, a subphase of separation-individuation (ages 15-24 months). Thus, it was proposed that fixation in that phase leads to problems in the establishment of object permanence that is necessary for the integration of the good and bad parts of the object (mother) and the self to have a healthy internalized object and self-representations (Clarkin et al., 2007). Therefore, intolerance to loneliness and intense anxiety towards separation in borderline patients are thought to stem from the explanations mentioned above (Kernberg, 1975).

Furthermore, Kernberg (1975) emphasizes the defense mechanism of splitting, which is quite prominent in borderline personalities. Splitting is developed to prevent

idealized representations from being contaminated by negative representations. Besides, individuals with BPD are adversely affected by intense and primitive uncontrolled emotions, and because of their distorted cognitive system, they experience difficulty in regulating these emotions appropriately. Thus, BPD could not be defined as only an affective disorder; it includes deterioration in the cognitive area (Kernberg, 2006).

Some crucial contributors, like Adler (1981) and Kernberg (1975), did not conceptualize borderline and narcissistic states as distinct phenomena; instead, they claimed that they lay on a continuum, and narcissistic personality had an upper position in there. Adler (1981) claimed borderline patients would reach a state similar to narcissistic personality with long-term psychotherapy, such as having a more cohesive sense of self.

However, Kohut (1977) believed that borderline personality disorder and narcissistic personality disorder are separate concepts and cannot be seen as a continuum because he asserted that narcissistic patients have a cohesive self in contrast to borderline patients, who have a fragmented self (Kohut, 1979; Schmidt, 2019). However, Kernberg used the term "borderline" in a broad sense, like an organization, so he classified narcissistic personality disorder as a subtype of the borderline organization since he believed that they have similar peculiarity; both of them use defense mechanisms of splitting, projective identification, denial, omnipotence and also have similar ego structure (Schmidt, 2019). Nevertheless, narcissistic patients have a more integrated self-concept than borderline patients because, unlike borderline patients, their "grandiose" self can hold both bad and sound objects. Besides, they are better at impulse control and social functioning than borderline patients (Schmidt, 2019; Tonkin & Fine, 1985). Kernberg (1975) considered borderline organization as a developmental fixation. Kohut viewed developmental fixations because of caregivers' failure to respond to the child's developmental needs, which may lead to traumatic disappointments in the child's mind.

Further, if caregivers' soothing abilities cannot alleviate these frustrations, it could manifest themselves as borderline states when the self perceives themselves in a situation of danger (Kohut, 1971; Mitchell & Black, 2016). To sum up, Kohut and

Kernberg differ in their emphasis on which part of the self is more prominent in developing the pathologic narcissistic self: the grandiose one or the shamed one (Schmidt, 2019). Thus, it could be possible to see a reflection of these differences in their clinical practice and techniques with narcissistic and borderline patients.

It is also important to emphasize that borderline personality organization could be seen as an umbrella term; it has a broad spectrum, and borderline personality disorder as a diagnostic term demonstrates the subgroup of borderline personality organization (Kernberg, 2006). The Diagnostic and Statistical Manual of Mental Disorders (DSM) included borderline personality for the first time in its third revision in 1980. In the fourth edition (1994), transient paranoid and dissociative symptoms under highly stressful conditions were included as additional criteria. There was no change in the DSM-5 for BPD. It was characterized by a pervasive pattern of impulsivity, unstable personal relationships, identity diffusion, chronic feelings of emptiness, emotional dysregulation, inappropriate, intense anger, and transient paranoid thoughts or severe dissociation under stressful situations (DSM-5, 2013). For more detail, DSM-5 BPD criteria can be found in Table 1 (DSM-5, 2013).

Table 1

DSM-5 (2013) BPD Diagnostic Criteria

1. Frantic efforts to real or imagined abandonment.
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 and sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
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.
8. Inappropriate, intense anger or difficulty controlling anger.
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Note. Retrieved from American Psychiatric Association. (2022). Personality Disorders in *Diagnostic and statistical manual of mental disorders* (5th ed.)

It is widely known that people with borderline personality disorder face significant disturbances in social, occupational, and academic areas of life. For instance, a study involving 668 patients from several clinics found that patients with BPD showed more psychosocial impairments than those with major depressive disorder or obsessive-compulsive disorder (Skodol et al., 2002). Individuals with borderline personality disorder suffer from problematic interpersonal relationships because of the shifts between idealization and devaluation of others, and this is often due to an underlying fear of abandonment; they show a frantic effort to avoid real or imagined abandonment (Gunderson & Lyons-Ruth, 2008; Larrivée, 2013; Zeigler–

Hill & Abraham, 2006). In other words, hypersensitivity to interpersonal relationships and various situations in social contexts is a prominent feature of BPD (Gunderson & Lyons-Ruth, 2008; Jovev & Jackson, 2006; Kernberg, 1967). Recent studies revealed that traumas, particularly attachment-related traumas, are prominent in developing borderline organization (Blatt & Levy, 2003; Bowlby, 1977; Fonagy & Bateman, 2008; Levy et al., 2005; Ross, 2007). Thus, borderline organization is a complex term; presumably, it might be determined by several factors. In this sense, an in-depth investigation of BDP and its symptoms with underlying factors is valuable for literature and clinical practice.

1.1. Epidemiology

The different results of epidemiological studies partially stem from the theoretical and methodological differences between studies. Nevertheless, it could be said that the prevalence of borderline personality disorder is approximately 1-2% in the general population (Ellison, 2018). However, the actual prevalence rate is considered to be slightly higher, which is attributed to misdiagnosis and to the fact that prevalence ratings in the normal population vary among different sociodemographic features. For instance, a study conducted by Have et al. (2016) showed that increased borderline personality symptoms are related to decreased education level, increased instability in job situations (having no paid jobs), and long-term romantic relationships. In this sense, more epidemiological studies are needed to shed more light on sociodemographic variability. The prevalence rate in primary care settings is roughly 6%, and within outpatient clinical health services, it rises to 20% (Bozzatello et al., 2021). In addition, the prevalence of BPD among those who seek plastic surgery is also significantly higher (Morioka & Ohkubo, 2014).

BPD shows high comorbidity with other mental disorders, including major depression, anxiety disorders, eating disorders, other DSM Axis I disorders, as well as alcohol and drug abuse (Çalışır, 2008; Grant et al., 2008; Ellison, 2018; Kaess et al., 2013; McGlashan et al., 2000). Comorbidity between Major Depressive Disorder (MDD) and BPD is highly prevalent, and there are shared vulnerabilities that contribute to the severity of symptoms (Yoshimatsu & Palmer, 2014). Moreover, a meta-analysis has shown that individuals with both BPD and MDD tend to be more resistant to treatment, with limited positive responses to medications or psychotherapy (Newton-Howes et al., 2014). Furthermore, research has examined the impact of

depression on Theory of Mind (ToM) abilities and has revealed that while affective ToM performance remains unaffected by depression, cognitive ToM performance is indeed influenced by depressive symptoms (Zabinzadeh et al., 2017). Therefore, it is important to control for depressive symptomatology when examining ToM performance with regard to borderline personality organization.

Borderline Personality Disorder is three times more common in women than men (APA, 2013; Bozatello et al., 2021; Çalışır, 2008; Ellison, 2018). However, Tomko et al. (2014) found no significant difference between females and males regarding the diagnosis of BDP. They argued that these differences emanate from diagnostic or sampling errors in addition to sociodemographic characteristics.

Studies have shown that age is also a relevant factor for BPD. However, there has been a historical debate regarding diagnosing adolescents with borderline personality disorder, which has not been fully resolved yet (Larrivée, 2013; Levy et al., 1999; Miller et al., 2008). There are several reasons behind this controversy: It is claimed that BPD diagnosis is not valid for adolescents, symptoms cannot be differentiated easily due to the effects of puberty because they are similar in some respects (e.g., emotional instability, anger outbursts, etc.), it might be hard to figure out which is caused by which, and due to stigmatized perception of BPD, clinicians are usually reluctant to diagnose adolescents with BPD (Kaess et al., 2014). On the other hand, there is a consensus in the literature that younger individuals are more likely to have BDP than older ones; in other words, symptoms fade with older age (Ellison, 2018; Paris, 2003). In particular, the incidence of BPD decreases considerably over 60 years of age. A study conducted by Ames and Molineri (1994) demonstrated that prevalence of the BPD was 1% in a sample of 200 people aged 60 and over. Early detection and prevention studies revealed that the prevalence of BPD in adolescents is compatible with adult prevalence (Sharp & Romero, 2007; Wertz et al., 2019). Also, the gender difference observed in the adult population is not detected in the adolescent population (Levy et al., 1999).

1.2. Etiology

The etiology of borderline personality disorder is not fully understood but is thought to result from environmental, psychological, and biological factors. In the literature, preliminary discourses about the causes of BPD are childhood sexual and

physical abuse (Paris, 2009; Van der Kolk et al., 1994; Zanarini, 2000), parental maltreatment (Belsky et al., 2012; Bradley et al., 2005; Herman et al., 1989), genetic and neurophysiological factors (Krause-Utz et al., 2014; New et al., 2007; Schulze et al., 2016).

The study conducted by Paris et al. (1994) shed light on the risk factors for BPD in childhood; they compared 78 women with BPD and 72 women without BPD diagnosis. The authors revealed that the BPD group reported more childhood sexual abuse (CSA) than the comparison group in the interview. Furthermore, the BPD group was exposed to more severe CSA and had more severe physical abuse than the non-BPD group. They found that CSA is the most discriminative risk factor for developing BPD. Thus, traumatic events are considered one of the predisposing factors, especially those that occur in early childhood when the child cannot find anyone to alleviate his/her intense feelings (Kulacaoglu & Kose, 2018). Also, there was a meta-analysis about the relationship between childhood adversity and BPD. It also revealed similar findings that childhood adversity is significantly associated with BPD. So, childhood adversity and neglect appear more frequently in BPD groups than in those without BPD (Porter et al., 2020).

However, it should be noticed that some studies claim that the risk of developing BPD increases significantly when combined with genetic predisposition, which is not as effective as early childhood traumas alone, as shown in the literature (Fossati et al.,1999; Leichsenring et al., 2011; New et al., 2008; Paris, 1998). A meta-analysis study conducted by Amad et al. (2014) showed that environment and gene interaction have an important effect on the development of BPD, but they conceptualized genes are not directly related to the pathogenesis of BPD; instead, the frequency of positive and negative life events and one's way of dealing with them affect the gene-environment interaction, a process known as epigenetics. According to American Psychological Association, genetic heritability rates are dramatically high if a person has a first-degree relative with BPD; the risk is five times higher for that person compared to the general population (DSM-5, 2013). Further, Skoglund et al. (2019) conducted a study with 1,851,755 BPD participants to investigate the familial risk and heritability rate, and their results showed that the heritability of BPD was around 46%. Genetic vulnerability is also related to several neurophysiological alterations in the brain (Choudry et al., 2017). There are several hypotheses about the

neurophysiological components of BPD, one of which claims that specific brain regions, including the amygdala, hippocampus, insula, and prefrontal cortex, that are involved in the regulation and processing of emotions, show decreased volume in BPD (Ruocco et al., 2012). In conclusion, the etiology of BPD is complex and has not been fully discovered.

1.4. Theory of Mind

Theory of mind (ToM), also known as mentalizing, is a complex ability crucial for social interaction (Baron-Cohen, 1995). It can be conceptualized as the ability to understand, interpret, and make inferences about what is going on in someone else's mind and also awareness of people having different mental states from each other (Frick et al., 2012; Premack, Woodruff, 1978).

Premack & Woodruff (1978) were among the first researchers to focus on children's ability to distinguish their and others' mental states while considering reality using a False Belief Task (Wimmer, 1983). They found that a 4-year-old child has sufficient ability to accomplish this test and therefore argued that ToM emerges around four years (Permer & Wimmer, 1985). However, more recent studies revealed that children might develop this ability much earlier, around 15 months (Baillargeon et al., 2010). Studies suggest that ToM development is related to several areas of functioning. For instance, children with advanced ToM abilities have a better academic and social life, view their relationship with peers more positively, and show more prosocial behaviors compared to those with lower-level ToM abilities (Fink et al., 2015; Imuta et al., 2016; Slaughter et al., 2015; Wellman, 2015).

ToM is defined into two subprocesses: mental state decoding (affective ToM) and mental state reasoning (cognitive ToM). The affective part of ToM involves understanding one's emotions, and the cognitive part of ToM refers to an understanding of one's intentions and beliefs (Németh et al.,2018). Furthermore, these distinctions have been supported with neural underpinnings by brain imaging studies; for instance, the ventromedial prefrontal cortex (vmPFC) has a particular role in affective ToM (Shamay-Tsoory et al., 2006). These relatively independent processes are assessed via different tasks: For instance, Reading the Mind in the Eyes Test (RMET, Baron-Cohen, 2001) focuses on decoding (affective ToM). The test consists of photographs of faces with different emotions, and participants are expected to infer

the mental states of the faces based on subtle cues in the eye region. Faux-pas task (Stone et al., 1998), on the other hand, assesses both reasoning (cognitive) and decoding (affective) parts. In this test, participants are presented with stories including inappropriate behaviors in social situations, and it is observed whether they can recognize how inappropriate these behaviors are (Sabbagh, 2004; Şandor & İşcen, 2021; Németh et al., 2018).

ToM impairments appear to be related to numerous developmental, neuropsychiatric, and psychological problems, including autism spectrum disorders, schizophrenia, some types of dementia (e.g., frontotemporal dementia), and Alzheimer's disease (Baron-Cohen, 1995; Bora et al., 2015; Brewer et al., 2017; Chung et al., 2013; Kimhi, 2014). Furthermore, among personality disorders, BPD is the most researched personality pathology concerning ToM. BPD patients have a significant impairment in social cognition, which is also a reason for problematic interpersonal relationships which they suffer from (Arntz et al., 2009; Roepke et al., 2013; Sharp & Sieswerda, 2013).

1.4.1 ToM and BPD

There are controversial findings in the literature about ToM deficits in BPD; several studies have shown that BPD patients have intact or even advanced emotion recognition and ToM skills (Arntz et al., 2009; Lynch et al., 2006; Minzenberg et al., 2006). On the other hand, some studies have found that BPD patients have hyper-ToM rather than lack of ToM; i.e., they are hyper-sensitive to others' mental states and more vigilant to negative social cues (Dinsdale et al., 2015; Frick et al., 2012; Sharp, 2015). However, these controversies are thought to be caused by the multifaceted nature of ToM and methodological differences in studies. A recent meta-analysis conducted by Bora (2021) revealed that ToM skills are significantly impaired in BPD patients compared to healthy controls. However, when the components were examined separately, no significant deficit was observed in decoding mental state, but reasoning ToM as well as Reflective Functioning (RF) were found to be significantly impaired among individuals with BPD compared to healthy controls (Bora, 2021; Németh et al., 2018). In other words, basic ToM skills were generally intact in BPD patients, but difficulties could be more apparent in more complex and demanding ToM tasks. For instance, participants with BPD performed significantly worse in the Faux-pas task, which needs higher-level ToM skills for using different perspectives

during the decision-making process (Petersen et al., 2016). In this sense, it is argued that BPD patients do not have primary neuro-interpretation biases in processing social information (Bora, 2021).

1.5. Mentalization

Mentalization and ToM are often used interchangeably and synonymously in the literature, but still, there is a nuance. As an umbrella term, mentalization refers to several dimensions, including cognition and affect; self and others (Luyten & Fonagy, 2015). Fonagy and Bateman (2006) defined mentalization as a capacity for subjectively understanding and making sense of the mental states of oneself and others. The researchers also assert that genuine mentalization requires appreciating the opaqueness of mental states while being able to accurately infer and interpret one self's and the other's mental states and behaviors. This capacity develops during the early years via healthy interactions with parents. Mentalization is closely linked to attachment and reflective functioning, which involve the capacity to reflect on and make sense of one's and others' emotional experiences (Fonagy & Bateman, 2006). Also, the reflective function is an operational definition of mentalization. In line with this, Fonagy et al. developed a Reflective Functioning Scale in 2016 to measure mentalization capacity. Luyten and Fonagy (2015) conceptualized four dimensions of mentalization: "automatic vs. controlled," "self-directed vs. other-directed," "external vs. internal," and "cognitive vs. affective." Automatic mentalization involves quick, spontaneous, and intuitive understanding of others' mental states; it is also indicated that BPD patients generally rely on automatic mentalization rather than cognitive, which is a more effortful facet of mentalization (Fonagy & Luyten, 2018). Self-oriented and other-oriented facets are related to the directionality of the mentalizing process, awareness of one's mental states and intentions, or attending to and understanding others' mental states, thoughts, and emotions. External mentalizing refers to making inferences about the external world, including other people's behaviors and social cues. In contrast, internal mentalizing ability is related to making inferences about oneself and the capacity to explore one's inner states, thoughts, and emotions. Cognitive mentalizing, on the other hand, involves the use of cognitive processes such as reasoning and logical thinking to understand others' mental states or intentions, whereas the affective part emphasizes the role of emotions and empathic attunement to comprehend or relate to other's emotional states (Luyten & Fonagy,

2015; Luyten et al., 2020). Besides, there are several explanations asserted by Fonagy and Bateman (2008) about decreased mentalization capacity: When the child is exposed to traumatic events and traumatized people, the child may suppress the ability to mentalize other people's ideas and intentions as a defense mechanism. Secondly, the increase in the stress level due to stressful situations encountered at an early age is responsible for decreased activity in the specific brain region (orbitofrontal cortex) which is believed to be involved in mentalization capacity. Lastly, traumas activate the attachment system, deactivating reflective functioning due to the urgent need for secure attachment (Fonagy & Bateman, 2008). Thus, if the child cannot have sufficient emotional mirroring or develops disorganized attachment patterns as a result of their interactions with the parents, they may develop poor mentalization ability, which, in turn, is associated with problems in social cognition and in adulthood, it manifests itself as difficulties in interpersonal relationships due to problems for understanding others' and oneself emotions, intentions, and beliefs (Fonagy & Bateman, 2008). In line with this, they proposed that mentalization ability (including social cognition, reflective functioning, and metacognition) is a core personality feature (Fonagy & Bateman, 2008). Thus, the dysfunctional personality traits, particularly in the case of borderline personality disorder, as well as other psychopathologies such as eating disorders and major depression, may stem from a deteriorated ability to mentalize (Fonagy & Bateman, 2016; Kuipers & Bekker, 2012; Luyten et al., 2012). Fortunately, it is known that mentalization capacity is not an innate or unchangeable ability, rather, it is a capacity that can be developed throughout life, and in this sense, it can be improved not only through primary caregivers or family (dyadic attachment) but also via the social environment, friends, and even the therapist (Luyten et al., 2020). Therefore, it can be concluded that individuals with BPD often have a diminished ability to mentalize, but this can be improved through various psychotherapeutic interventions, such as Mentalization-Based Therapy (Fonagy & Bateman, 2008; Fonagy & Bateman, 2016; Goueli et al., 2019). Therefore, focusing on reflective functioning capacity, which is changeable and improvable, and developing new interventions regarding it, can significantly support individuals who experience mentalization problems or related issues. Obtaining more knowledge in this field can benefit individuals who face such challenges.

1.6. Attachment in BPD

According to attachment theory pioneer Bowlby (1969, 1973), an infant's interaction with the caregiver significantly impacts their future feelings, ideas, and behaviors. Bowlby also developed the concept of "internal working models" in attachment theory, inspired by the object relations school in psychoanalytic theory. He proposed that the internal working model is formed through reinforcement, where the child's behavior is shaped by the caregiver's responses. In this way, the child develops an internal representation of the caregiver as a source of security and comfort, and this model works as a reference for future relationships (Bowlby, 1977). Bowlby identified four main attachment styles: secure, avoidant, ambivalent, and disorganized (Bowlby, 1969). Secure attachment is characterized by trust, emotional openness, and the ability to form strong, long-lasting relationships with a positive self-image (Bretherton, 1992). Avoidant attachment is marked by emotional distance and fear of intimacy, often resulting from the caregiver's lack of responsiveness or abusive parenting (Fraley, 2002). Ambivalent/resistant attachment involves a preoccupation with the caregiver's availability, leading to emotional dependency and anxiety in relationships (Cassidy et al., 2016). Disorganized attachment is characterized by inconsistent and confused responses to a caregiver, and it is associated with significant social and emotional difficulties. This attachment style is believed to stem from inconsistent or abusive caregiving experiences, resulting in unresolved fears and conflicting emotions toward the caregiver (Fraley, 2002).

Hazan and Shaver (1988) applied attachment theory to adult romantic relationships, and they argued that the attachment style that people develop in childhood is carried into adulthood and influences the way people form and maintain romantic relationships (Ainsworth et al., 1971; Hazan & Shaver, 2017). Numerous studies have been conducted about the relationship between borderline personality and attachment, and it could be argued that there may be a link between BPD and attachment styles. However, there has been uncertainty about which type of insecure attachment is most salient in BPD. Some studies have found that individuals with BPD tend to have an anxious/ambivalent attachment style, characterized by a fear of abandonment and lack of trust in others, and this can manifest itself in intense and unstable relationships, as well as a tendency to cling to others or push them away (Flowers et al., 2018; Lorenzini & Fonagy, 2013). On the other hand, some studies

have found that avoidant attachment is the most common type of attachment in BPD (Levy et al., 2015). Smith & South (2020) showed that attachment anxiety, as well as attachment avoidance, is significantly correlated with BPD traits. Thus, they concluded that there is a strong association between BPD and attachment disorganization (Smith & South, 2020).

To sum up, there have been considerable gaps and uncertainties in the literature about the relationship between attachment, reflective functioning, ToM, and borderline personality traits. In addition, when we examine the psychodynamic formulation and etiology of borderline personality organization, we can also consider several influential factors, such as early childhood traumas and attachment issues. By incorporating these variables into the study, we can explore how these factors impact both borderline personality and the theory of mind, examining their relationship. understanding borderline personality traits and their relation with the concepts mentioned above may shed light on developing effective clinical interventions for this debilitating and complex mental disorder.

1.7. Goals and Hypotheses of the Study

This study aims to investigate the relationship between borderline personality traits and theory of mind (ToM) skills via Faux Pas Tasks which assessed both cognitive and affective aspects of ToM. Additionally, the study will examine the association between borderline personality traits, reflective functioning (RF), adverse childhood events, and attachment. Based on previous literature suggesting that depression might disrupt ToM performance, a depression scale was also included to be able to control for depressive symptomatology, if necessary.

Hypotheses:

H_1: Participants with high borderline personality traits are expected to perform worse on faux pas task (as measured by total faux pas scores) compared to those with low borderline traits.

H_2: There will be a negative correlation between Borderline Personality Scale and Reflective Functioning Scale, indicating a negative relationship between hypomentalization and borderline traits.

H_3: There will be a significant positive relationship between Borderline Personality Scale and False positive errors in the faux pas task.

Also, for explorative analysis, the relationship between different sociodemographic variables (including age, education level and trauma history) and borderline personality traits will be analyzed. Finally, the study will investigate the relationship between reflective functioning, borderline personality traits, and attachment style to understand how these difficulties become manifest in close relationships.

2. METHOD

2.1 Sample Characteristics

The sample comprises 70 participants aged between 19 and 58 years *(M = 24.3, SD = 6.5)*. Participants were selected via convenience sampling, including university students and older adults. University students were mainly from Yeditepe University and became aware of the study and agreed to participate for extra credit through announcements made in undergraduate courses. In addition, the remaining participants were invited to participate through announcements made in their surroundings. Moreover, all participants voluntarily participated in the study. The sample includes 51 women (72.9%) and 18 men (25.7%). Also, one participant specified their gender as genderfluid (1.4%).

2.2 Materials

2.2.1. Sociodemographic Form

In this study, participants were asked to provide information on their age, gender, socioeconomic status (SES), education level, and psychiatric diagnosis (if applicable). Additionally, participants were asked a single yes or no question to indicate whether they had experienced childhood trauma. (See Appendix A).

2.2.2. Faux Pas Task (FPT)

Faux pas task (Stone et al., 1998; Baron-Cohen et., 1999) was developed to assess both cognitive and affective domains of ToM. The task consists of 20 short stories, 10 of which are faux pas stories (FP), and 10 are control stories (CS) that do not consist of faux pas. This task has no time limits, and participants can take their time to read and apprehend the stories. Faux pas refers to someone saying something that should not be said or something that sounds irritating or insulting to the other

person in the story. At the end of each story, participants are asked whether there is a faux pas in the story *("Did anyone say something they should not have said or something awkward?")*, Furthermore, if the answer is "yes," then they are asked, "*Who said something they should not have said or something awkward?*" 4 more questions are asked to identify whether the participant could perceive the intentions, beliefs, and emotions of the main characters in the story. The first five questions refer to the cognitive components of ToM, and the last question *("How do you think X felt?)* refers to the affective component of ToM. (Stone et al., 1998). The first question pertains to detecting faux pas, while the second question is related to identifying the person responsible for committing the faux pas. The correct response to the third question indicates the participant's ability to comprehend the mental states of the listener. The fourth question requires the participant to understand the speaker's mental state (Stone et al., 1998). In faux pas stories, participants receive one point for each correct answer. The maximum score that could be obtained in each faux pas story is six. On the other hand, two points are given for a correct answer to the control story question. Therefore, the highest point that could be obtained from each control story is two. There are 10 faux pas stories, and the highest score that could be obtained from them is 60. In addition, there are 10 control stories without faux pas, and the maximum number of points one can receive from this section is 20. Thus, the highest score in the task is 80. False negative errors refer to the participant mistaking the faux pas story as the control story, and false positive errors refer to the participant mistakenly identifying control story as the faux pas story. The false negative error score is equal to the number of faux pas stories identified as control stories. In other words, if there are 2 incorrect identifications, the participant receives 2 points. The same scoring applies to false positive errors. Both the original version of the task and the Turkish version have robust psychometric properties; for the Turkish version, internal consistency reliability for FP stories was 0.94 for faux pas, and 0.92 for control stories (CS). Inter-rater reliability was 0.88 for FP stories; 0.96 for CS stories. Inter-rater reliability was found to be 0.88 for FP stories and 0.96 for CS (Şandor & İşcen, 2021). (See Appendix A).

2.2.3. Experiences in Close Relationships (ECR-R)

The ECR-R is an adult attachment scale developed by Fraley, Waller, and Brennan in 2000 to measure attachment based on anxiety and avoidance. It consists of

36 items, 18 measuring attachment anxiety (e.g., I am afraid that I will lose my partner's love), and 18 assessing attachment-related avoidance (e.g., I find it difficult to allow myself to depend on romantic partners). The participants are asked to rate each item on a 7-point scale, ranging from "strongly disagree" to "strongly agree" (Fraley et al., 2000). Anxiety and avoidance scores are calculated for each participant. For each subscale, higher scores indicate higher levels of attachment avoidance, and attachment anxiety also increases. (Fraley et al., 2000). Selcuk and colleagues (2005) adapted the scale to Turkish and analyzed to determine the validity and reliability of the Turkish version. The original version of the scale has robust statistical properties, as well as the Turkish version. Regarding statistical properties of the Turkish version, both avoidance and anxiety dimensions have robust internal reliability, and Cronbach's alpha coefficients for these dimensions are .90 and .86, respectively. Besides, test-retest reliability was also satisfactory for both dimensions: .81 for avoidance and .82 for anxiety dimension (Selcuk et al., 2005). In the present study, the Cronbach alpha coefficient was found as .91 for the avoidance subscale and .89 for the anxiety subscale. The findings were consistent with previous research. (See Appendix A).

2.2.4. Borderline Personality Inventory (BPI)

BPI was designed by Leichsenring in 1999 to assess borderline personality organization based on Kernberg's structural personal organization theory. It is fundamentally based on identity confusion, primary defense mechanisms, and reality testing. BPI is a self-report scale with 53 yes/no items (Leichsenring, 1999). The original version had good psychometric properties; Cronbach's alpha internal consistency coefficient was found as 0.91 (Leichsenring, 1999). Turkish adaptation of the scale was conducted by Aydemir and colleagues in 2006. The Turkish version also had robust levels of reliability, which was .92 for the overall study group; .84 for the borderline personality disorder group. Test re-test correlation was found to be 0.67, and according to ROC analysis, the cut-off point was determined as 15/16 (Aydemir et al., 2006). For the present study, the Cronbach alpha internal consistency score was found to be .86, consistent with previous studies. (See Appendix A).

2.2.5. Reflective Functioning Questionnaire (RFQ-8)

RFQ-8 was designed to measure mentalizing capacity in a brief and easy way, and it primarily focuses on individuals with borderline personality traits (Fonagy et

al., 2016). This study used the 8-item short version (See Appendix A). It includes 8 questions rated on a 7-point Likert scale (completely disagree (1) to completely agree (7)). RFQ-8 has two subscales: uncertainty of mental states and certainty of mental states (RFQ-u and RFQ-c). The scoring system for the 7-point Likert scale was different for the two subscales. The scale contained six items that measured the level of certainty about mental states and were related to the RFQ-c subscale. To obtain an optimal degree of certainty score, these items were recoded as follows: 1=3, 2=2, 3=1, 4=0, 5=0, 6=0, 7=0. Therefore, higher RFQ-c scores indicate optimal certainty about mental states. Additionally, the RFQ-u subscale consisted of six items to assess hypomentalizing. The items related to this subscale were recorded as follows: 1=0, 2=0, 3=0, 5=1, 6=2, 7=3 (but there is an exception for item 7; it is recorded as RFQ-c). According to this, higher scores indicate problematic degrees of uncertainty about mental states. However, recent studies criticize the two-factor structure of the scale and show that the psychometric properties of the two-factor structure are problematic and insufficient in measuring certainty dimension (hypermentalization) (Dal, 2021; Horváth et al., 2023; Müller et al., 2020; Spitzer et al., 2020). Therefore, using the scale as unidimensional yields more accurate results. Considering these arguments, the current study used the scale as a single factor measure of mentalization (uncertainty or hypomentalization). In this sense, there are some changes in the scoring procedure of the scale: there is no item other than "7" that is reverse-coded; only item 7 is reverse-coded. Other items are coded as specified in the scale. So, higher scores indicate hypomentalization and lower scores indicate high degrees of certainty. The original version of the scale has sufficient statistical properties (Fonagy et al., 2016). Turkish version of the scale is available for research purposes, and it can be found on the following website: https://www.ucl.ac.uk/psychoanalysis/research/reflective-functioning-questionnaire-rfq. Kahya and Munguldar (2022) studied the psychometric properties of the Turkish scale in a non-clinical adolescent sample. They found satisfactory statistical reliability and validity. Cronbach alpha values of RFQ-c and RFQ-u were 0.72 and 0.65, respectively (Kahya & Munguldar, 2022). The unidimensional version of the Turkish scale also shows good psychometric properties; Dal (2021) investigated the psychometric properties of the Turkish version of RFQ-8 and demonstrated satisfactory reliability, with a Cronbach alpha value of 0.82. In this

study, the RFQ scale was considered a unidimensional structure, an internal consistency analysis was performed, and Cronbach alpha was found as .76.

2.2.6. Beck Depression Scale

BDI is a 21-item self-report scale to assess depression (Beck et al., 1961). Participants are asked to indicate the presence and severity of depressive symptoms on a 4-point Likert scale (0 to 3). The scores are interpreted as follows: 0-9 normal functioning, 10-18 mild depression, 19-29 moderate depression, and 30-63 severe depression (Beck, 1961). BDI was adapted to Turkish by Hisli (1989). Original and Turkish versions of BDI have robust psychometric properties. The Cronbach alpha value for the Turkish version was obtained as .80 (Hisli, 1989). (See Appendix A).

2.3. Procedure

The data collection process was carried out on Zoom, an online video conferencing platform. The main reason behind this choice was to make reaching participants and making appointments easier and more convenient. In addition, even if the Covid-19 situation is controlled and restrictions were lifted everywhere when the data collection began, this method was found to be safer due to the uncertain and unpredictable nature of the pandemic at that time. Appointments were made via email with individuals who were willing to participate in the study. Then the first part was a Zoom section, and participants were first administered the Faux Pas Task. Then they were expected to fill out the questionnaire, which consisted of the Informed Consent (see Appendix B), Demographic Form, Experiences in Close Relationships (ECR-II), Borderline Personality Inventory, Reflective Functioning Questionnaire, and Beck Depression Scale (see Appendix A). Finally, after completing the scales, participants were presented with a Debriefing form (see Appendix C). Qualtrics, an online data collection platform, was used for data collection, and the data collection process continued from June 2022 to December 2022. The current study was approved by Yeditepe University Ethics Board (See Appendix D).

2.4. Data Analysis

Data analysis was conducted using Statistical Package for Social Sciences (SPSS), version 26. Initially, all continuous variables were checked for normality violation. Skewness and kurtosis values were considered to examine normality violation, in addition to visual inspection via Q-Q plots. A range of -3 to +3 was accepted for skewness and kurtosis values (George & Mallery, 2021), and it was assumed that

variables falling within this range did not violate the normality assumption. The only variable that exceeded these cut-offs was BPS total score; therefore, nonparametric statistics (Spearman correlation and Mann-Whitney U test) were used for analyses that included BPS.

On the other hand, Pearson correlation and independent samples t-test were utilized to analyze further the other variables that did not violate the normality assumption. To compare participants' scores on the Borderline Personality Scale, the sample as into two groups based on the median value. Group 1 comprised participants who scored between 2 to 7 on the scale, indicating a low score. Group 2 included participants who scored between 8 to 36, indicating a higher score. This grouping allowed for a comparative analysis of the participant's scores on the scale. There was no data extraction from the study, as the analysis was conducted with a sample of 70 participants. The alpha value was set as .05.

3. RESULTS

3.1 Sociodemographics of the Participants

Table 2 presents the sociodemographic characteristics of the sample. The study included 70 participants, mostly female (n=70; 72.9%). The age range of the participants ranged from 19 to 58 years, with the majority falling within the young adult category (19 to 29 years; n=70; 90%). Regarding education levels, many participants held a bachelor's degree (n=70; 74.3%). Concerning socioeconomic status, out of the 70 participants, only one participant (1.4%) reported perceiving their socioeconomic status as lower. 39 participants (55.7%) perceived their socioeconomic status as middle; 23 participants (32.9%) perceived their socioeconomic status as upper-middle, and 7 participants (10%) perceived their socioeconomic status as upper. These findings indicate that most participants perceived their socioeconomic status as middle or above. Regarding education levels, most participants had completed higher education, with a significant proportion holding a master's degree. 41 participants (58.6%) reported experiencing childhood trauma, and 18 (25.7%) participants reported psychiatric history.

Table 2

Sociodemographic Characteristics of the Sample

Sociodemographic Variables	*N*	*%*
Gender		
Female	51	72.9
Male	18	25.7
Genderfluid	1	1.4
SES		
Low	1	1.4
Middle	39	55.7
Upper middle	23	32.9
Upper	7	10
Education		
High School	2	2.9
Associate degree	3	4.3
Bachelor	52	74.3
Master	13	18.6
Childhood Trauma		
Yes	41	58.6
No	29	41.4
Psychiatric History		
Yes	18	25.7

No	52	74.3
Age		
19-29	63	90
30-40	4	5.7
41-51	2	2.8
58	1	1.4

3.2. Descriptive Statistics and Normality Examination of the Study Variables

Table 3 presents the mean scores, standard deviations, and skewness-kurtosis statistics for the study variables, including the Reflective Functioning Scale, Borderline Personality Scale, Total score of Faux Pas Task with sub scores for Faux Pas Story and Faux Pas Control Story, Experiences in Close Relationships II Anxiety and Avoidance scores, and Beck Depression Scale.

Table 3

Descriptive Statistics of the Variables

	N	Mean	SD	Skewness	Kurtosis
Reflective Functioning Scale	70	29.79	9.06	-.245	-.920
Borderline Personality Scale	70	9.29	6.54	1.505	3.247
Faux Pas Task Total	70	64.60	10.35	-1.116	.987
1.FP-Story	70	46.43	10.09	-1.331	1.677
2.FP-Control	70	18.17	2.09	-1.271	1.437
3.False Negative	70	1.03	1.63	1.845	2.955
4.False Positive	70	.91	1.05	1.271	1.437
ECR-II-Anxiety	70	3.51	1.07	.399	.020
ECR-II-Avoidance	70	2.79	1.07	.742	.168
Beck Depression Inventory	70	14.91	10.78	1.162	.577

Note. FP story: Faux pas story score, ECR-II: Experiences in Close Relationship II

3.3. The Relationship between Borderline Personality Traits, Attachment, Reflective Functioning, and Depression

The results of Spearman rank order correlation showed that there was a significant positive relationship between Borderline Personality score and ECR-

Anxiety scores (r_s= .437, n=70, p<.001), and there was also a positive significant relationship between Borderline Personality Scale and ECR-Avoidance scores, (r_s= .282, n= 70, p= .018). It was found that Borderline Personality Scale and depression scores were significantly and positively correlated, r_s = .526, n=70, p<.001. Also, there were positive and significant correlations between Borderline Personality Scale and RFQ scores, r_s = .341, n = 70, p=.002. However, there was not found any significant relationship between Reflective Functioning and Depression scores (see Table 4).

Table 4

Intercorrelations between Borderline Personality Trait, Attachment, Reflective Functioning, and Depression Scores

Variables	1	2	3	4	5
1. BPS	-	.437**	.282*	.341**	.526**
2. ECR-Anxiety		-	.435**	.335**	.544**
3. ECR-Avoidance			-	.028	.290*
4. RFQ				-	.221
5. Depression					-

Note. N=70 **p< .01, *p <.05

BPS: Borderline Personality Scale, RFQ: Reflective Functioning Scale, ECR: Experiences in Close Relationships Scale

3.4. The Relationship between Borderline Personality Traits, Reflective Functioning, and Theory of Mind

The results of correlation analyses indicated no significant relationship between Borderline Personality Scale and Faux pas Total, Faux pas Story, and Faux pas Control scores (p >.05). There was, however, a positive significant relationship between BPS and FP-False Negative errors (r_s = .243, n = 70, p= .04), but not with False Positive errors (Figure 1 depicts the relationship between BPS and FP-false

negative scores). Furthermore, a significant positive relationship was obtained between BPS and RFQ, $r_s = .341$, $n = 70$, $p = .002$. (See Table 5).

Table 5

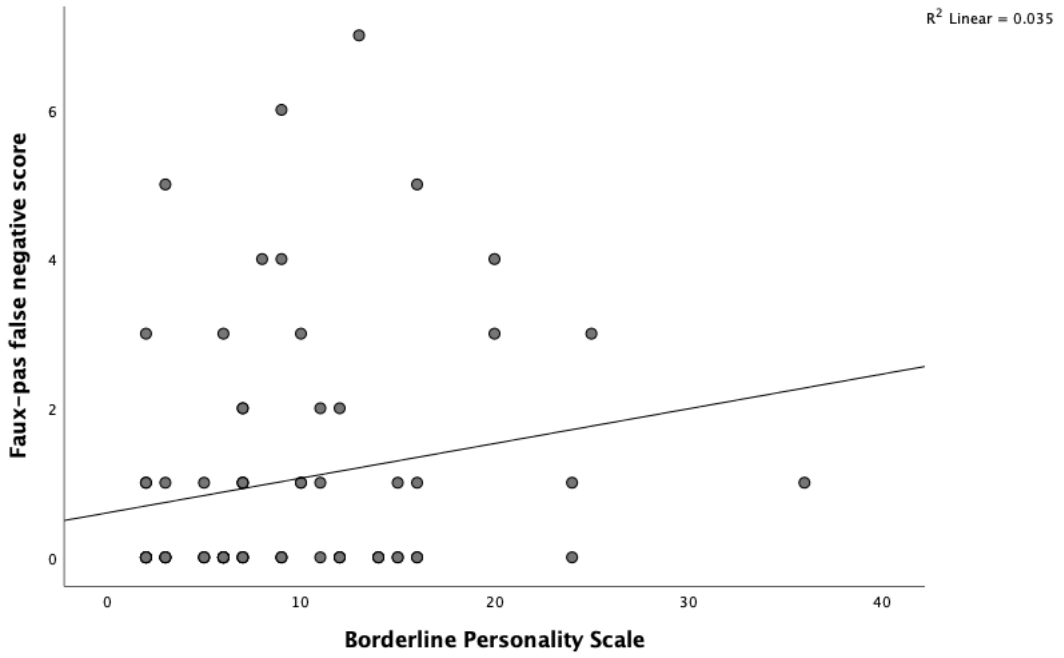
Correlations between Borderline Personality Traits, and Faux Pas Scores

Variables	1	2	3	4	5	6	7
1. BPS	-	-.211	-.176	-.112	.243*	.112	.341**
2. FP-total		-	.140	.215*	-.904**	-.225*	.141
3. FP-story			-	.125	-.823**	-.125	.140
4. FP-control				-	-.009	-1.00**	.103
5. FP-false negative					-	-.041	-.045
6. FP- false positive						-	-.150
7. RFQ							-

Note. N=70, **p<.01, *p<.0 BPS: Borderline Personality Scale, FP: Faux Pas Task, RFQ: Reflective Functioning Questionnaire

Figure 1

Scatterplot Depicting the Correlation between BPS and Faux Pas False Negative Errors



3.6. Comparison Between High and Low Borderline Personality Score Groups Regarding Faux Pas Scores

The participants with lower borderline personality scores had significantly higher scores (*Mdn*= 69, *n*= 37) on the total faux pas compared to participants with higher borderline personality scores (*Mdn*=65, *n*= 33). False Negative error rate was significantly higher in participants in the high borderline personality group (*Mdn*=1.00, *n*=33) compared to participants in the low borderline personality group (*Mdn*=.00, *n*= 37). None of the remaining FP scores significantly differed between the groups (See Table 6).

Table 6

Mann Whitney-U test Results for Comparing Borderline Personality Scale Groups

Variables	Group	N	Mean Rank	Sum of Rank	U	Z	Sig
Total FP	Low	37	40.39	1494.50	429.500	-2.13	**.033**
	High	33	30.02	990.50			
FP- Story	Low	37	39.58	1464.50	459.500	-1.78	.075
	High	33	30.92	1020.50			
FP- Control	Low	37	37.58	1390.50	533.500	-.96	.333
	High	33	33.17	1094.50			

False	Low	37	31.01	1147.50	444.500	-2.18	**.029**
Negative	High	33	40.53	1337.50			
False Positive	Low	37	33.42	1236.50	533.500	-.96	.333
	High	33	37.83	1258.50			

Note. FP: Faux pas, RFQ: Reflective Functioning Scale

3.7 The Relationship between Sociodemographic Variables, BPS, and Faux Pas Scores

With regard to gender, there was no significant difference between the FP total scores of female (*M*= 64.96, *SD*= 9.32) and male participants (*M*= 65.39, *SD*= 10.78); *t*(67)= -.161, *p* >.05. Similarly, borderline personality scores did not significantly differ among female (*Mdn*= 7, *n*= 51) and male group (Mdn= 8, *n*= 18), *U* = 416.500, *p* >.05.

Age was not significantly correlated with BPS (r_s = -.135, *n* =70, *p* >.05), or FP total scores (*r* = -.129, *n* =70, *p* >.05) .

The results of the Mann Whitney-U test indicated a significant difference in BPS scores between participants who experienced childhood trauma and those who did not, revealing that BPS scores were significantly higher in childhood trauma group (*Mdn*= 40.59, *n*= 41) compared to the no childhood trauma group (*Mdn*= 28.31, *n*= 29), *U* =386.000, *z*= -2.50, *p*= .013, with moderate effect size *r*= .30. The results of the independent samples t-test showed that there was not observed a significant difference between participants who experienced childhood trauma (*M*= 64.32, *SD*= 10.98, *n*= 41) and those who did not (*M*= 65.00, *SD*= 9.58, *n*= 29) regarding total Faux pas scores, (*t*(68)= .27, *p*> .05).

4.DISCUSSION

4.1 Overview of the Study

In the literature, research on borderline personality disorder (BPD) and Cognitive or Affective Theory of Mind (ToM) has yielded contradictory findings. To the best of our knowledge, this is the first study that investigates BPD and ToM skills, including error types (false positives and false negatives), using the faux pas task in a Turkish sample. In the current study, we had 70 participants from the general population, mostly early adults. Firstly, we observed a significant difference between the two groups when comparing the total faux pas scores of participants who scored

high and low on the borderline personality scale. Participants who scored lower on the borderline scale had a higher total faux pas score than those who scored higher, indicating that participants with fewer borderline personality traits performed better on the faux pas test overall. However, we did not find any significant difference in faux pas story scores and control story scores between groups.

Further, Reflective Functioning Scale and Borderline Personality Scale were positively and significantly correlated, indicating a positive relationship between borderline traits and dysfunctional reflective functioning (hypomentalization). Besides, among different ToM scores, BPS was only significantly correlated to FP false-negative scores, although a group comparison also yielded lower Total FP performance for the group with higher BPS scores. Hence, H_1 was supported, but H_2 and H_3 were not supported.

Further, with regard to the relationship between borderline personality traits and attachment types, BPS score was positively correlated with both attachment avoidance and attachment anxiety. Finally, the explorative analysis results revealed neither age nor gender were significantly related to faux pas or BPS scores. On the other hand, there was a significant difference between participants who had childhood trauma and those with no childhood trauma regarding the borderline personality scale; participants who had childhood trauma received higher scores on the borderline personality scale compared to participants who had not experienced childhood trauma. However, there no significant difference between trauma groups was observed regarding total faux pas scores.

4.2 Findings Related to Faux Pas Task Performance and Borderline Personality Traits

One of the aims of the current study was to investigate the relationship between borderline personality traits and complex ToM abilities via faux pas task (FPT) with a detailed scoring method including Error types, Total FPT scores, and FPT story.

4.2.1. Findings Related to Total FP Scores, FP Story Scores, and Control Story Scores

In the current study, the between-group analysis showed a significant difference in total faux pas scores between groups. Participants in the high borderline trait group received lower scores in faux pas task compared to low borderline trait group. This finding was in line with previous studies (Baez, 2014; Németh et al., 2020; Pluta et

al., 2018; Zabinzadeh et al., 2017). In the literature, it is known that detection of subtle differences in ToM performance in BPD requires complex tasks (e.g., MASC, faux pas) that require making inferences about mental states and intentions of others and understanding false beliefs and assessing both aspects of ToM, affective and cognitive (Petersen et al., 2016). It can be asserted that one of the reasons for the contradictory results encountered in the literature is the choice of assessment tools used to measure theory of mind. Different assessment tools may lead to differences in the obtained results. For instance, RMET (Baron-Cohen et al., 2001) is one of the most frequent tasks to assess ToM performance, but it examines simpler ToM and affective ToM, not cognitive ToM (Bora, 2021; Harari et al., 2010). Specifically, there are some studies indicating there was no difference regarding ToM ability between BPD and healthy controls (Berenson et al., 2018; Ghiassi et al., 2010; Mier et al., 2013) and others asserted BPD participants have superior ToM compared to the control group (Arntz et al., 2009; Fertuck, 2009; Frick et al., 2012) and these studies generally used RMET to assess ToM, or other different tasks (e.g., Brüne Cartoon Task), so we suspect that the reasons behind the mixed results are related to task preference and methodological differences. However, despite the significant difference in faux pas scores between the low and high borderline groups, we did not find a significant correlation between borderline personality symptoms (BPS) and total faux pas scores. However, when we examined the correlation analysis using a one-tailed approach, we found that it was significant. Nevertheless, upon reviewing the literature, we observed that one-tailed tests are not commonly preferred. Therefore, we chose to report our results based on the two-tailed test outcomes. Therefore, we can argue that the differences are only apparent when we divide BPS scores into levels (high and low), and there is a distinction between borderline levels based on total faux pas scores. This discrepancy could be attributed to the non-normal distribution of the BPS scores, with most scores falling in the low range. Consequently, the lack of a significant correlation between BPS and total faux pas scores may be due to the distribution of the data, and we can only identify meaningful differences by categorizing the BPS scores into groups.

Regarding faux pas story, no significant difference was found between groups. This can be explained by again related to negative interpretation bias for neutral situations, which indicates control stories, and enhanced performance and attention on negative situations, which indicates faux pas stories. So, participants with high

borderline traits did not show any significant difference in faux pas story scores compared to the low borderline group, they performed similar to participants with low borderline traits. Also, FP control story scores also did not significantly differ between groups. Also, the study conducted by Pluta et al. (2018) with female participants with or without BPD found significant differences between the groups regarding faux pas stories. The study consisted of 30 female participants who had BPD diagnosis and 30 female participants as healthy controls. Women with BPD performed significantly worse on the faux pas story and all faux pas tasks than female participants without BPD. Similarly, these different findings in the literature may be related to differences in sample characteristics. In this study, the participants were drawn from the general population; therefore, we did not have sufficient number of participants who had BPD diagnosis. Thus, the scores obtained from the borderline personality scale generally fell within lower ranges.

4.2.2. Faux Pas Task Error Types: False Negative and False Positive

Correlational analysis showed that there was no significant correlation between borderline personality traits and FPT-false positive errors. It was found that there was a significant positive correlation between FPT- false negative errors. Also, the between-group analysis showed that the high borderline personality trait group showed significantly more false negative errors than the low borderline group. However, there was not found any significant difference in false positive errors between groups. So, our findings were contradictory to our hypothesis. However, based on previous studies, we expected that individuals with high borderline traits tend to hypermentalize and attribute negative valence to neutral situations, so it was supposed that they tend to make false positive errors. For example, research on emotion recognition from facial expressions has shown that participants with BPD misattribute neutral faces as negative emotions (Daros et al., 2013; Domes et al., 2008; Dyck et al., 2009; Scott et al., 2011) and a meta-analysis on RMET scores and BPD revealed significant difficulty in identifying neutral stimuli compared to healthy controls (Richman & Unoka, 2015).

Additionally, a recent study by Kılıç et al. (2020) found that individuals with BPD had lower accuracy when identifying neutral faces compared to a control group. However, no significant difference between positive and negative faces was found.

So, it can be asserted that BPD traits are related to an enhanced ability to detect negative stimuli and a tendency to biased interpretation of neutral situations.

However, our results were consistent with a study conducted by Pluta et al. (2018), who investigated 30 women with a BPD diagnosis and 38 healthy women as the control group. They found that women with BPD identified faux pas stories as control stories more often than the healthy controls (false negative error). Regarding our study, the control stories in our experiment were "neutral" situations, so we hypothesized that participants with high borderline traits would be more prone to make negative attribution to these neutral scenarios. Specifically, we expected them to make a false attribution about a behavior that committed a faux pas or an embarrassing situation. From another perspective, it may be important to note that this finding is consistent with another finding. We observed that participants showing higher borderline personality traits were prone to false negative errors, which could be attributed to hypomentalization. Additionally, we observed that participants with higher borderline personality traits also obtained higher scores on the reflective functioning scale, indicating a greater tendency towards hypomentalization. Thus, these two findings appear to be aligned. Nonetheless, it is possible that these results were obtained due to Type II errors resulting from the small sample size. Furthermore, the majority of participants scored lower on the borderline personality scale, indicating a floor effect. As a result, we were unable to capture the full range of the borderline personality spectrum.

Furthermore, task type may have an impact on the results. For instance, Movie for the Assessment of Social Cognition (MASC) (Dziobek et al., 2006) is a more ecologically valid test and have a more complex scoring system to detect hypermentalization, hypomentalization, accurate mentalization, and no mentalization; studies that were utilized MASC found findings consistent with our expectation (Andreou et al., 2015; Cortés -Garcia et al., 2021; Sharp et al., 2013; Somma et al., 2019). Besides, although Normann-Eide et al. (2019) found a significant relationship between BPD and hypermentalization, they provide alternative explanations for this relationship, suggesting that hypermentalization cannot be solely explained by the presence of BPD. Instead, they argue that the symptom severity and presence of any personality disorder, in general, is related to hypermentalization.

4.3 Findings Related to Reflective Functioning and BPD

Correlational analysis showed a significant positive relationship between RFQ and borderline personality scale, indicating a positive relationship between increased borderline personality traits and distorted mentalization capacity (hypomentalization). Although these results contradict our initial hypothesis, we expected that borderline personality traits and hypermentalization would be positively correlated, based on the findings of previous studies (Dinsdale et al., 2015; Sharp et al., 2015). A study conducted with adolescents with BPD and healthy controls showed that hypermentalization was significantly higher in adolescents with BPD than other types of RF dysfunctions compared to healthy controls (Quek et al., 2019). However, our findings align with the literature that indicates distorted RF in BPD (Badoud et al.,2018; Morandotti et al., 2018; Perroud et al., 2017). Because we expected that there would be distortion in reflective function in participants with more borderline traits, but we assumed that this distortion resulted from excessive mentalization, namely hypermentalization, not lack of mentalization (hypomentalization). However, these studies utilized RFQ scales as a two-dimensional approach RF_u and RF_c, but regarding the studies, RFQ could not accurately assess the certainty dimension (Euler et al., 2021; Müller et al., 2020; Spitzer et al., 2020), which means that these studies (Badoud et al., 2018; Morandotti et al., 2018; Perroud et al., 2017) might not be sufficient in assessing the certainty dimension and may have only shown one aspect of impaired mentalization (uncertainty). This issue is similar to the measurement tool limitation in our study. Euler et al. (2021) conducted a study with BPD patients to investigate the relationship between interpersonal problems and reflective function, and they found that hypomentalization predicts interpersonal problems, but hypermentalizing did not predict it, also other studies found similar findings in adolescents' uncertainty about mental states (hypomentalization) associated with BPD (Duval et al., 2018; Kahya & Munguldar, 2022). Another study by Sharp et al. (2013) revealed contradictory results, the study conducted with adolescents and they showed that hypermentalization was found to be a significant core component rather than hypomentalization in adolescents with BPD. However, parallel to our hesitation, Euler et al. (2021) asserted that this ambiguity in assessing mentalization whether the RF-uncertainty dimension reflects an adaptive or maladaptive aspect of mentalizing may contribute to the inconsistent results across studies. Besides, other moderators; different age groups (adolescents vs. young adults and adults), using different RFQ

scales (extended version or short version), and scoring the RFQ as a two dimensional or unidimensional approach might influence the obtained results.

As previously mentioned, the literature generally agrees that impaired reflective functioning is a core feature of BPD, as we have also shown in our study. However, there has been no consensus on the impairment type. Given the issues with the construct validity of the RFQ-c identified by Müller et al. (2021), further research using reliable measurement tools is necessary to assess both dimensions of mentalizing with good construct validity.

4.3.1 Unidimensional Approach for RFQ-8

In the previous sections, we discussed the calculation and psychometric properties of the RFQ-8, both in one-dimensional and two-dimensional forms. However, this section will provide a more detailed explanation of why we chose to approach the scale as one-dimensional in the current study. Recent studies in the literature investigate the psychometric properties of the RFQ-8 scale, which is found questionable in terms of the two-dimensional structure, asserting that the certainty dimension of the scale is problematic regarding the double scoring system (same items used as reversed to score both dimensions) and using same items for different scales yielding artificial correlations. Also, the semantic structure of the scale is problematic for a two-dimensional approach.

In other words, the scale measured certainty by negating uncertainty, posing a face validity problem (Müller et al., 2020; Spitzer et al., 2020). Moreover, the study to validate the RFQ-8 scale in a non-clinical Turkish sample revealed that with confirmatory factor analysis, a two-dimensional structure was assessed for whether it was suitable for the data. Results showed that the two-dimensional model did not fit the data well, whereas the one-dimensional model fit well (Dal, 2021). In this sense, we decided to use RFQ-8 as a unidimensional scale.

4.4. Explorative Analysis

4.4.1 Attachment, Childhood Trauma and Borderline Personality Traits

Interpersonal conflicts, negatively biased perceptions toward others, and hypersensitivity to abandonment and rejection are prominent features of BPD. The literature emphasizes that early relationships with caregivers, childhood maltreatment, and emotional invalidation contribute to psychosocial risk factors when combined with biological factors in explaining BPD symptomology or borderline-related

symptoms and the development of maladaptive attachment patterns (such as insecure and disorganized attachment styles) in adulthood and romantic relationships (Fonagy et al., 2000; Gunderson & Lyons-Ruth, 2008; Khoury et al., 2020; Levy et al., 2015; Paris et al., 1993). Previous studies on BPD and attachment styles have yielded similar results to our findings. For instance, attachment anxiety and avoidance are found to be significantly linked with borderline personality in a study investigating the relationship between attachment and borderline personality related symptoms (Godbout et al., 2019). A meta-analysis study investigated which attachment dimension is the most prominent one in BPD. The findings of the study revealed that both dimensions of attachment (anxiety and avoidance) are concurrently present and absent in BPD participants, so they argued that these dimensions interact with each other, so rather than the correlation, focusing on their interaction is more beneficial (Smith & South, 2019). In the current study, we found both dimensions (anxiety and avoidance) to be positively correlated with BPS scores. Correspondingly, when considering these findings in conjunction with existing literature, it suggests that the fearful/disorganized attachment style, which is a combination of anxious and avoidant attachment (Ainsworth et al., 1971), may be the most explanatory and associated attachment style for borderline personality disorder (MacDonald et al., 2013; Scott et al., 2009). That is because individuals with borderline personality disorder exhibit sharp fluctuations in their perception of self, the world, and others, inconsistency and extremes in closeness-distance dynamics, and chaotic and unstable patterns in relationships, all of which align with the features of fearful/disorganized attachment. Furthermore, it can be argued that the splitting defense mechanism, the most prominent defense mechanism in borderline personality disorder, is also accounted for by this attachment style (Smith & South, 2019).

Upon closer examination of the data in the current study, although no significant difference was found between the groups regarding attachment categorizations, it was observed that a higher proportion of participants in the high borderline group (16 out of 33 participants) fell into the fearful categorization. In contrast, only 8 participants in the low borderline group were classified as fearful, in line with the literature (Hashworth et al., 2021). However, we did not consider attachment types as a categorical approach. Instead, we analyze attachment as a dimensional approach since the developers of the original version of the ECR-R (Fraley et al., 2000) have concerns about power and precisions to use the scale as

categorical because of the dimensional nature of the attachment concept. Therefore, considering these concerns, we analyzed attachment dimensionally in the current study. In conclusion, to deepen understanding of the attachment dimensions and BPD, further studies can rely on more observational data, not solely on self-report, and different relationship contexts, not just romantic relationships.

Further, the body of the research showed that most of the BPD patients had traumatic childhood experiences in line with our findings. Participants in the high borderline group reported more childhood trauma than those in the low borderline group (Bouchard et al., 2009; Cohen et al., 2014). It can be claimed that traumatic experiences during childhood with caregivers can allow individuals to develop negative beliefs about themselves, which can, as expected, lead to interpersonal difficulties, problematic relationship patterns, and symptoms resembling borderline personality disorder in adulthood (Godbout et al., 2019). However, our study did not explore further details of traumatic experiences as it was not the main focus of our research. Therefore, we did not gather specific information about childhood traumatic experiences with caregivers to infer their relationship with borderline personality disorder or personality-related symptoms.

4.4.2 Borderline Personality Traits and Depression

The existing literature has extensively explored the relationship between depression, particularly major depressive disorder (MDD), and borderline personality disorder (BPD). It has been argued that personality disorders and MDD commonly coexist, with BPD being the most prominent among them (Beatson & Rao, 2013; Gunderson et al., 2008). In the current study, we obtained consistent results with the literature. Specifically, there was a significant positive relationship between borderline traits and depressive symptomatology.

Nevertheless, there is an ongoing debate about whether depression affects ToM performance in BPD patients, and several studies have yielded contradictory results. For instance, a study by Fertuck et al. (2009) demonstrated that depression positively impacted RMET performance in the BPD group. In contrast, another study found that RMET performance did not differ regarding depression severity in BPD patients (Frick et al., 2012). Moreover, a study by Zabihzadeh et al. (2017) investigated the impact of comorbidity between borderline personality disorder (BPD) and major depressive disorder (MDD) on Theory of Mind (ToM) abilities. They

indicated that the BPD group with comorbid MDD (BwM) performed the poorest in the faux pas task in contrast to results of the affective ToM tasks (RMET), suggesting that depression plays a role in exacerbating cognitive deficits in Theory of Mind (ToM) abilities. In the current study, we did not control depression as a confounding variable. However, future studies can check MDD in participants.

Besides, it was observed that demonstration of the depressive symptoms differs in individuals with borderline personality disorder, unlike the usual experience of sadness or guilt. Instead, it is marked by emotions like anger, intense shame, isolation, and an overwhelming feeling of emptiness, self-criticism, and dependency instead of typical symptoms of guilt, sadness, and anhedonia (Wilson & Stanley, 2007; Yoshimatsu & Palmer, 2014). However, the current study did not explore the specific manifestations of depressive symptoms in individuals with comorbid BPD compared to those without BPD, nor did it investigate shared vulnerabilities. These aspects are beyond the scope of the present study and warrant further research to develop integrated treatment approaches for resistant patients with comorbid BPD and depression.

4.4.3 Gender Differences in BPD

In the literature, the issue of gender differences in the borderline personality disorder (BPD) population has been extensively discussed, and a consensus has emerged indicating that women are diagnosed with BPD more frequently than men (APA, 2013; Bozatello et al., 2021; Ellison et al., 2018). In this study, gender differences in borderline personality groups were investigated as an explorative analysis. However, we found that borderline personality scores did not significantly differ based on gender. Even though our findings contradict with several studies in the literature (ten Have et al., 2016; Ellison et al., 2018), this contradiction may stem from sample size and lower representations of males compared to females in our sample, and also could not represent broader borderline personality spectrum due to lack of normal distribution in the borderline personality scale, we could not capture the severe cases. However, some epidemiological studies found no gender differences in BPD groups in line with the current study (Tomko et al., 2014). Tomko et al. suggested that differences between genders regarding BPD may be caused by sampling bias. Because women are observed to be more proactive in seeking psychological help compared to men, which leads to a misleadingly higher diagnosis

rate in women and a higher presence of women in clinical settings. However, this seems to be associated with cultural and gender norms rather than men receiving fewer borderline personality disorder (BPD) diagnoses than women.

4.5 Limitations and Recommendations for Future Studies

This study has several limitations. Firstly, it was not a longitudinal study but rather a cross-sectional one, which does not allow for establishing causal or predictive relationships. Future studies could consider utilizing a longitudinal design to investigate cause-and-effect relationships. Additionally, since we collected data at a single point in time, there is a possibility that we may have missed some critical data.

Besides, due to our relatively small sample size, we could not reach the broad range of borderline personality organization, which also affects the non-normal distribution of the borderline personality scale. Most of the scores were under the cut-off point (floor effect). Therefore, it impacted the representativeness of the data, and we could not represent the participants with more borderline personality organization traits. Also, we had more female participants. Further studies can strive to maintain an equal ratio of male and female participants.

Moreover, for future studies, it is recommended that prior to data collection, participants undergo screening using a semi-structured measurement tool such as the SCID-II (First et al., 1997) to assess borderline personality organization. However, despite recognizing this ideal methodology's importance, we could not allocate the necessary resources. Conducting such screenings requires teamwork and funding, which were unavailable for our study.

The same limitation applies to the faux pas task we used to measure the theory of mind. Since it was not a team effort, a single person coded and scored the faux pas test. However, in an ideal methodology, a second independent rater should have been involved in coding and scoring to ensure inter-rater reliability. On the other hand, despite the faux pas task's good psychometric properties and ecological validity, the Movie for the Assessment of Social Cognition (MASC) task, as introduced by Dziobek et al. (2006), offers even greater ecological validity as it is a video-based task. Furthermore, the MASC task allows for a more detailed and systematic investigation of the theory of mind errors through its four-category scoring system (no mentalization, accurate mentalization, hypomentalization, and hypermentalization). Also, MASC includes a time limit, so it increases pressure and stress on participants

whereas in faux pas there was no time limit; participants could read the scenarios several times, and the response time was not recorded and taken into consideration. Further studies can put a time limit or assess their response time. However, it should be noted that the MASC task has not been adapted for use in the Turkish language. Therefore, future studies could also focus on adapting the MASC task for Turkish-speaking populations, allowing for exploring the theory of mind in a more ecologically valid context.

Furthermore, as discussed in the relevant sections, the RFQ (Reflective Functioning Questionnaire) exhibited some psychometric issues, which may have affected our results. The RFQ only assesses one dimension known as hypomentalization, thus limiting our ability to assess hypermentalization adequately. Additionally, the scale items primarily focus on the self-oriented aspect of mentalization rather than the other-oriented aspect (Fonagy et al., 2016; Dal, 2021). In the literature, other scales assess mentalization broadly, encompassing various aspects (e.g., CAMSQ or MentS, Müller et al., 2021; Dimitrijević et al., 2017). However, these scales have not yet been adapted for use in the Turkish population. Therefore, developing more comprehensive measurement tools for the Turkish sample would significantly contribute to the literature. Alternatively, employing an interview format for assessing reflective functioning could be considered.

Lastly, we used self-report methods, which are susceptible to participants providing biased responses. Thus, combining different methods may be a better option for future studies.

4.6 Clinical Implications

In therapy, it is known that clients in therapy bring up topics related to social relationships and interpersonal problems, and nowadays, mentalization is highly preferred to handle both interpersonal problems and self-awareness regarding emotions and beliefs as a transdiagnostic approach (Luyten et al., 2020; Richter et al., 2021). In this sense, our study showed that borderline personality traits are linked to impaired reflective function. However, it would be beneficial for clinicians to utilize interview-based assessments for reflective function to explore this relationship further and obtain more comprehensive and precise information. This methodology would enable clinicians to gather in-depth and detailed data, enhancing the clinical implications of the findings. Also, our findings support attachment anxiety and

avoidance in BPD. In this sense, it can be asserted that using and developing intervention techniques (Mentalization Based Therapy as an example of this) that are addressed to enhance reflective functioning, theory of mind, and secure attachment in patients with borderline personality traits would be important in the treatment of borderline pathologies (Fonagy & Target, 1997; Bateman & Fonagy, 2004).

5. CONCLUSION

In this study, we investigated the relationship between Borderline Personality traits and Theory of mind using by faux pas task, which is specifically designed to measure both the cognitive and affective aspects of the ToM. Furthermore, the relationships between Borderline personality traits and other psychological factors, including reflective functioning, adverse childhood events, depression, and attachment were also explored. We found that participants in the high borderline trait group had lower faux pas total scores than those in the low borderline trait group. In other words, the low borderline group performed better on the faux pas task based on total faux pas scores. Further, we found no difference between groups regarding story and control scores in the faux pas task. Besides, participants in the high borderline group tended to make more false negative errors than the low borderline trait group. Moreover, increased scores on BPS were related to higher scores on the reflective functioning scale, indicating a tendency towards hypomentalization in borderline personality organization. Furthermore, both attachment anxiety and attachment avoidance appeared to be related to borderline personality organization, indicating a possible disorganized attachment pattern in BPD. Also, those with a history of childhood trauma scored higher on BPS compared to those did not report childhood trauma. Further, there was no significant difference observed between trauma groups regarding total faux pas scores. Lastly, no significant results were obtained with regard to age and gender.

The literature on borderline personality and Theory of mind, especially cognitive aspects of the ToM, yielded mixed results. This current study will contribute to the literature with its findings. The number of studies conducted in Turkey to understand the relationship between borderline personality disorder and Theory of mind is quite limited. Therefore, the existing studies in the Turkish literature lack comprehensive examinations of theory of mind, encompassing both cognitive and emotional aspects, as well as studies focusing on more complex theory of mind skills. Future research

can take into account the limitations and recommendations of this study to conduct new research in this field, and they can focus on developing more ecologically valid and comprehensive tasks to measure Theory of Mind and Mentalization.

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Appendix A: Sociodemographic Form and Scales

1. Sociodemographic Form

1-) Cinsiyetiniz nedir? ( ) Kadın ( ) Erkek ( ) Diğer: ____ ( ) Belirtmek İstemiyorum

2-) Yaşınız: ___ (Lütfen sayı ile belirtiniz)

3-) Öğrenim durumunuz nedir?

( ) Okur-yazar

( ) İlkokul

( ) Ortaokul

( ) Lise

( ) Ön lisans

( ) Lisans

( ) Yüksek Lisans

( ) Doktora

4-) Sosyo-ekonomik düzeyinizi nasıl algılıyorsunuz?

( ) Düşük

( ) Orta

( ) Orta-üstü

( ) Yüksek

5-) Psikiyatrik bir tanınız var mı: _____ (var ise belirtiniz, yoksa hayır yazabilirsiniz)

6-) Çocukluğunuzdan hatırladığınız, travmatik sayılabilecek sizi duygusal olarak etkileyen bir anınız var mı?

( ) Evet

( ) Hayı

2. Experiences in Close Relationships- II (ECR-II)

Yakın İlişkilerde Yaşantılar Ölçeği-2

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Bu araştırmada sizin ilişkinizde yalnızca şu anda değil, genel olarak neler olduğuyla ya da neler yaşadığınızla ilgilenmekteyiz. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer halihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde işaretleyiniz.

1--------- 2---------3---------4----------5---------6---------7

Hiç Karasızım/Fikrim yok. Tamamen

Katılmıyorum. Katılıyorum.

1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım.	1	2	3	4	5	6	7
2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.	1	2	3	4	5	6	7
3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım.	1	2	3	4	5	6	7
4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissederim.	1	2	3	4	5	6	7
5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım.	1	2	3	4	5	6	7
6. Romantik ilişkide olduğum kişilere güvenip inanmak konusunda kendimi rahat bırakmakta zorlanırım.	1	2	3	4	5	6	7
7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsediğim kadar önemsemeyeceklerinden endişe duyarım.	1	2	3	4	5	6	7
8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır.	1	2	3	4	5	6	7
9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.	1	2	3	4	5	6	7
10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem.	1	2	3	4	5	6	7

11. İlişkilerimi kafama çok takarım.	1	2	3	4	5	6	7
12. Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim.	1	2	3	4	5	6	7
13. Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım.	1	2	3	4	5	6	7
14. Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım.	1	2	3	4	5	6	7
15. Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım.	1	2	3	4	5	6	7
16. Birlikte olduğum kişiyle kolayca yakınlaşabilirim.	1	2	3	4	5	6	7
17. Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam.	1	2	3	4	5	6	7
18. Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez.	1	2	3	4	5	6	7
19. Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur.	1	2	3	4	5	6	7
20. Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım.	1	2	3	4	5	6	7
21. Terk edilmekten pek korkmam.	1	2	3	4	5	6	7
22. Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir.	1	2	3	4	5	6	7
23. Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.	1	2	3	4	5	6	7
24. Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.	1	2	3	4	5	6	7
25. Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler.	1	2	3	4	5	6	7

26. Başımdan geçenleri birlikte olduğum kişiyle konuşurum.	1	2	3	4	5	6	7
27. Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.	1	2	3	4	5	6	7
28. Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim.	1	2	3	4	5	6	7
29. Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, "gerçek ben"den hoşlanmayacağından korkarım.	1	2	3	4	5	6	7
30. Romantik ilişkide olduğum kişilere güvenip inanma konusunda rahatımdır.	1	2	3	4	5	6	7
31. Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir.	1	2	3	4	5	6	7
32. Romantik ilişkide olduğum kişiye güvenip inanmak benim için kolaydır.	1	2	3	4	5	6	7
33. Başka insanlara denk olamamaktan endişe duyarım	1	2	3	4	5	6	7
34. Birlikte olduğum kişiye şefkat göstermek benim için kolaydır.	1	2	3	4	5	6	7
35. Birlikte olduğum kişi beni sadece kızgın olduğumda önemser.	1	2	3	4	5	6	7
36. Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar.	1	2	3	4	5	6	7

3. Reflective Functioning Scale (RFQ-8)

YANSITICI İŞLEYİŞ ÖLÇEĞİ-KISA FORM

Lütfen aşağıdaki cümleleri dikkatlice okuyunuz. Her bir cümle için, cümleye ne kadar katıldığınızı ifade etmek üzere 1 ile 7 arasında bir numara seçip cümlenin yanına yazınız. Cümleler üzerinde çok fazla düşünmeyin- ilk tepkiniz genellikle en iyisidir. Teşekkür ederiz.

1’den 7’ye kadar olan aşağıdaki ölçeği kullanın:

Kesinlikle Katılmıyorum	1	2	3	4	5	6	7	Kesinlikle Katılıyorum

1. İnsanların düşünceleri benim için bir bilinmezdir.
2. Neyi neden yaptığımı her zaman bilmem.
3. Sinirlendiğimde, neden söylediğimi gerçekten bilmediğim şeyler söylerim.
4. Sinirlendiğimde, sonradan pişman olacağım şeyler söylerim.
5. Eğer güvensiz hissedersem, diğerlerini sinirlendirecek şekilde davranırım.
6. Bazen neden yaptığımı gerçekten bilmediğim şeyler yaparım.
7. Ne hissettiğimi her zaman bilirim.
8. Güçlü duygular genellikle düşüncelerimi bulanıklaştırır.

4. Borderline Personality Scale

Borderline Kişilik Envanteri

Aşağıdaki cümlelerden size uygun olanı işaretleyiniz.

( ) Sık sık panik nöbetleri geçiririm.

( ) Son zamanlarda beni duygusal olarak etkileyen hiçbir şey olmadı.

( ) Çoğu kez gerçekte kim olduğumu merak ederim.

( ) Çoğu kez başıma iş açacak risklere girerim.

( ) Başkaları bana yoğun ilgi gösterdikleri zaman kendimi boğulmuş hissederim.

( ) Bazen içimde bana ait olmayan başka bir kişi ortaya çıkar.

( ) Gerçekte olmadığı halde acayip şekiller veya görüntüler gördüğüm oldu.

( ) Bazen çevremdeki insanlar ve nesnelerin gerçek olmadığını hissederim.

( ) Başkalarına yönelik duygularım bir uçtan bir uca çok hızlı değişir (Ör Sevgi ve beğeniden nefret ve hayal kırıklığına).

( ) Çoğu kez değersizlik ya da umutsuzluk duygusuna kapılırım.

( ) Çoğu kez paramı çarçur ederim ya da kumarda kaybederim.

( ) Gerçekte kimse olmadığı halde hakkımda konuşan sesler duyduğum oldu.

( ) "Gerçekte kimse olmadığı halde hakkımda konuşan sesler duyduğum oldu" cümlesi sizin için doğruysa cevap veriniz, değilse "hayır"ı işaretleyiniz.

( ) Bu sesler benim dışımdan gelmiştir.

( ) Bu sesler benim içimden gelmiştir.

( ) Hayır.

( ) Yakın ilişkilerde hep incinirim.

( ) Bana uymayan biçimde hissettiğim ya da davrandığım oldu.

( ) Bir kukla gibi dışarıdan yönetiliyormuş ve yönlendiriliyormuş gibi hissettiğim oldu.

( ) Herhangi birine fiziksel olarak saldırıda bulunduğum oldu.

( ) Düşüncelerim başkaları tarafından okunuyormuş gibi hissettiğim oldu.

( ) Bazen gerçekte suç işlemediğim halde, sanki işlemişim gibi suçluluk hissederim.

( ) Bilerek kendime bedensel zarar verdiğim oldu.

( ) Bazen gerçekte olmadığı halde insanların ve nesnelerin görünümlerinin değiştiği hissine kapılırım.

( ) Yoğun dini uğraşlarım olmuştur.

( ) Duygusal ilişkilerimde çoğunlukla ne tür bir ilişki istediğimden emin olamam.

( ) Bazen bir kahin gibi gelecekle ilgili özel hislerim olur.

( ) Bir ilişki ilerledikçe kendimi kapana kısılmış gibi hissederim.

( ) Gerçekte kimse olmadığı halde bir başka insanın varlığını hissettiğim oldu.

( ) Bazen bedenim ya da bedenimin bir kısmı bana acayip veya değişmiş gibi görünür.

( ) İlişkiler çok ilerlerse, çoğunlukla koparma gereksinimi duyarım.

( ) Bazen birilerinin peşimde olduğu hissine kapılırım.

( ) Sık sık uyuşturucu kullanırım (esrar, hap gibi).

( ) Başkalarını kontrol altında tutmaktan hoşlanırım.

( ) Bazen özel biri olduğumu hissederim.

( ) Bazen dağılıyormuşum gibi hissederim.

( ) Bazen bana bir şeyin gerçekte mi yoksa yalnızca hayalimde mi olduğunu ayırt etmek zor gelir.

( ) Çoğu kez sonuçlarını düşünmeden içimden geldiği gibi davranırım.

( ) Bazen gerçek olmadığım duygusuna kapılırım.

( ) Bazen bedenim yokmuş ya da bir kısmı eksikmiş hissine kapılırım.

( ) Çoğu kez kabus görürüm.

( ) Çoğu kez başkaları bana gülüyormuş ya da hakkımda konuşuyormuş hissine kapılırım.

( ) Çoğu kez insanlar bana düşmanmış gibi gelir.

( ) İnsanların kendi düşüncelerini benim zihnime soktuklarını hissettiğim oldu.

( ) Çoğu kez gerçekten ne istediğimi bilmem.

( ) Geçmişte intihar girişiminde bulundum.

( ) Bazen ciddi bir hastalığım olduğuna inanırım.

( ) Alkol, uyuşturucu ya da hap alışkanlığım vardır (herhangi birinde birinde olduğunu düşünüyorsanız işaretleyiniz).

( ) Bazen bir rüyada yaşıyormuş ya da yaşamım bir film şeridi gibi gözümün önünden geçiyormuş hissine kapılırım.

( ) Çoğu kez bir şeyler çalarım.

( ) Bazen öyle açlık nöbetlerim olur ki önüme gelen her şeyi silip süpürüyorum.

( ) Politika, Din, Ahlak (iyi-kötü) konuları ile ilgili sorulan sorularda çoğu kez kendimi rahatsız hissederim (3'ünden biri bile sizin için doğru ise işaretleyiniz).

( ) Bazen aklımdan birilerini öldürme düşüncesi geçer.

( ) Yasalarla başımın derde girdiği oldu.

5. Beck Depression Inventory

Beck Depresyon Ölçeği

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde bir çeşit ruh durumunu anlatmaktadır. Her maddede o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son bir hafta içindeki (şu an dahil) kendi ruh durumunuzu göz önünde bulundurarak, size en uygun olan ifadeyi işaretleyiniz.

1-) ( ) Kendimi üzüntülü ve sıkıntılı hissetmiyorum.

( ) Kendimi üzüntülü ve sıkıntılı hissediyorum.

( ) Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.

( ) O kadar üzüntülü ve sıkıntılıyım ki artık dayanamıyorum.

2-) ( ) Gelecek hakkında mutsuz ve karamsar değilim.

( ) Gelecek hakkında karamsarım.

( ) Gelecekten beklediğim hiçbir şey yok.

( ) Geleceğim hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.

3-) ( ) Kendimi başarısız bir insan olarak görmüyorum.

( ) Çevremdeki birçok kişiden daha çok başarısızlıklarım olmuş gibi hissediyorum.

( ) Geçmişe baktığımda başarısızlıklarla dolu olduğunu görüyorum.

( )Kendimi tümüyle başarısız biri olarak görüyorum.

4-) ( ) Birçok şeyden eskisi kadar zevk alıyorum.

( ) Eskiden olduğu gibi her şeyden hoşlanmıyorum.

( )Artık hiçbir şey bana tam anlamıyla zevk vermiyor.

( ) Her şeyden sıkılıyorum.

5-) ( ) Kendimi herhangi bir şekilde suçlu hissetmiyorum.

( ) Kendimi zaman zaman suçlu hissediyorum.

( )Çoğu zaman kendimi suçlu hissediyorum.

( )Kendimi her zaman suçlu hissediyorum.

6-) ( ) Bana cezalandırılmışım gibi geliyor.

( ) Cezalandırılabileceğimi hissediyorum.

( ) Cezalandırılmayı bekliyorum.

( ) Cezalandırıldığımı hissediyorum.

7-) ( ) Kendimden memnunum.

( ) Kendi kendimden pek memnun değilim.

( ) Kendime çok kızıyorum.

( ) Kendimden nefret ediyorum.

8-) ( ) Başkalarından daha kötü olduğumu sanmıyorum.

( ) Zayıf yanların veya hatalarım için kendi kendimi eleştiririm.

( ) Hatalarımdan dolayı ve her zaman kendimi kabahatli bulurum.

( ) Her aksilik karşısında kendimi hatalı bulurum.

9-) ( ) Kendimi öldürmek gibi düşüncelerim yok.

( ) Zaman zaman kendimi öldürmeyi düşündüğüm olur. Fakat yapmıyorum.

( ) Kendimi öldürmek isterdim.

( ) Fırsatını bulsam kendimi öldürürdüm.

10-) ( ) Her zamankinden fazla içimden ağlamak gelmiyor.

( ) Zaman zaman içinden ağlamak geliyor.

( ) Çoğu zaman ağlıyorum.

( ) Eskiden ağlayabilirdim şimdi istesem de ağlayamıyorum.

11-) ( ) Şimdi her zaman olduğumdan daha sinirli değilim.

( ) Eskisine kıyasla daha kolay kızıyor ya da sinirleniyorum.

( )Şimdi hep sinirliyim.

( )Bir zamanlar beni sinirlendiren şeyler şimdi hiç sinirlendirmiyor.

12-) ( ) Başkaları ile görüşmek, konuşmak isteğimi kaybetmedim.
( ) Başkaları ile eskiden daha az konuşmak, görüşmek istiyorum.
( ) Başkaları ile konuşma ve görüşme isteğimi kaybetmedim.
( ) Hiç kimseyle konuşmak görüşmek istemiyorum.

13-) ( ) Eskiden olduğu gibi kolay karar verebiliyorum.
( ) Eskiden olduğu kadar kolay karar veremiyorum.
( ) Karar verirken eskisine kıyasla çok güçlük çekiyorum.
( )Artık hiç karar veremiyorum.

14-) ( ) Aynada kendime baktığımda değişiklik görmüyorum.
( ) Daha yaşlanmış ve çirkinleşmişim gibi geliyor.
( ) Görünüşümün çok değiştiğini ve çirkinleştiğimi hissediyorum.
( ) Kendimi çok çirkin buluyorum.

15-) ( ) Eskisi kadar iyi çalışabiliyorum.
( ) Bir şeyler yapabilmek için gayret göstermem gerekiyor.
( ) Herhangi bir şeyi yapabilmek için kendimi çok zorlamam gerekiyor.
( ) Hiçbir şey yapamıyorum.

16-) ( ) Her zamanki gibi iyi uyuyabiliyorum.
( ) Eskiden olduğu gibi iyi uyuyamıyorum.
( ) Her zamankinden 1-2 saat daha erken uyanıyorum ve tekrar uyuyamıyorum.
( ) Her zamankinden çok daha erken uyanıyor ve tekrar uyuyamıyorum.

17-) ( ) Her zamankinden daha çabuk yorulmuyorum.
( ) Her zamankinden daha çabuk yoruluyorum.
( ) Yaptığım her şey beni yoruyor.
( ) Kendimi hemen hiçbir şey yapamayacak kadar yorgun hissediyorum.

18-) ( ) İştahım her zamanki gibi.

( ) İştahım her zamanki kadar iyi değil.

( ) İştahım çok azaldı.

( )Artık hiç iştahım yok.

19-) ( ) Son zamanlarda kilo vermedim.

( ) İki kilodan fazla kilo verdim.

( ) Dört kilodan fazla kilo verdim.

( ) Altı kilodan fazla kilo vermeye çalışıyorum.

20-) ( ) Sağlığım beni fazla endişelendirmiyor.

( ) Ağrı, sancı, mide bozukluğu veya kabızlık gibi rahatsızlıklar beni endişelendirmiyor.

( ) Sağlığım beni endişelendirdiği için başka şeyleri düşünmek zorlaşıyor.

( ) Sağlığım hakkında o kadar endişeliyim ki başka hiçbir şey düşünemiyorum.

21-) ( ) Son zamanlarda cinsel konulara olan ilgimde bir değişme fark etmedim.

( ) Cinsel konularla eskisinden daha az ilgiliyim.

( ) Cinsel konularla şimdi çok daha az ilgiliyim.

( ) Cinsel konular olan ilgimi tamamen kaybettim.

Appendix B: Informed Consent

EK-3
BİLGİLENDİRİLMİŞ GÖNÜLLÜ OLUR FORMU
Bu araştırma Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı bünyesinde Doktor Öğretim Üyesi Ezgi Soncu Büyükişcan danışmanlığında Ayşe Kazaca tarafından yürütülmektedir. Çalışmaya katılıp katılmama kararı tamamen size aittir. Katılmak isteyip istemediğinize karar vermeden önce araştırmanın neden yapıldığını, bilgilerinizin nasıl kullanılacağını, çalışmanın neleri içerdiğini, olası yararları ve risklerini ya da rahatsızlık verebilecek yönlerini anlamanız önemlidir. Lütfen aşağıdaki bilgileri dikkatlice okumak için zaman ayırınız. Çalışmaya katılmamakta veya çalışmadan herhangi bir zamanda ayrılmakta özgürsünüz. Çalışmaya katıldığınız için size herhangi bir ödeme yapılmayacak ya da sizden herhangi bir maddi katkı istenmeyecektir.
ÇALIŞMANIN AMACI: Araştırmanın amacı bazı kişisel özelliklerimiz ile sosyal durumları değerlendirme biçimlerimizi incelemektir.
ÇALIŞMAYA KATILMAMIN OLASI YARARLARI VE RİSKLERİ NELERDİR?
Çalışmaya katılmanız durumunda literatüre bu konu hakkında destek sağlayarak veri eklememize yardımcı olacaksınız. Çalışmanın öngörülen bir riski yoktur. Fakat çalışmada sizlere bazı negatif duygu durumlarına yönelik sorular sorulmaktadır. Bu sorularda kullanılan ifadeler bazıları için rahatsızlık verici olabilir. Böyle bir durumda katılımınızı sonlandırma hakkına sahipsiniz. Eğer bu olumsuz duyguları sizde yoğun rahatsızlık yaratırsa araştırmacıyla iletişime geçerek bir ruh sağlığı uzmanına yönlendirilme konusunda destek alabilirsiniz.
KİŞİSEL BİLGİLERİM NASIL KULLANILACAK?
Çalışma dahilinde kimlik bilgileriniz toplanmayacaktır. Sağladığınız diğer veriler yalnızca araştırma dâhilinde kullanılacaktır. Elde edilecek bilgiler araştırmacılar tarafından toplu halde değerlendirilecek ve bilimsel alanda rapor edilmek için kullanılacaktır. Talep etmeniz durumunda bu onam formunun bir örneği size iletilecektir.
SORU VE PROBLEMLER İÇİN BAŞVURULACAK KİŞİLER :
Ad-Soyadı/E-posta adresi : Ayşe Kazaca
Çalışmaya Katılma Onayı
Bu bilgilendirilmiş onam belgesini okudum ve anladım. Bu araştırmaya katılmayı hür irademle kabul ediyorum.

Appendix C: Debriefing Form

ARAŞTIRMA SONRASI BİLGİLENDİRME FORMU

"Do Borderline Traits Make People More Sensitive? Relationship Between Borderline Personality Traits and Mentalization Capacity" başlıklı çalışma sona ermiştir. Katılımınız için teşekkürler. Bu çalışmada sınır kişilik (Borderline) özellikleri ve zihinselleştirme kapasitesi arasındaki ilişkiyi ve ikinci olarak, sınır kişilik özelliklerinin olumsuz çocukluk deneyimleri ve yansıtıcı işlevsellik (reflective functioning) ile ilişkisi de incelenerek sınır kişilik özellikleri ile ilgili daha derinlikli bilgi edinmeyi amaçladık. Bu çalışma sonucu çıkan verilerin literatüre hem teorik hem pratik anlamda katkı sağlayacağını düşünmekteyiz. Çalışma kapsamında sağladığınız veriler ve çalışma sonuçları bilimsel ve mesleki etik ilkeleri çerçevesinde korunacak, sonuçlar toplu olarak yorumlanıp yalnızca bilimsel yayın amacıyla toplu bilgiler halinde paylaşılacaktır. İzlediğimiz prosedürün katılımcılarda bir rahatsızlık yaratmayacağı düşünülmektedir. Ancak katılımınızla ilgili bir problem yaşarsanız veya çalışmaya dair herhangi bir sorunuz olursa araştırmacıya aşağıdaki e-posta adresinden ulaşabilirsiniz. Çalışmanın sağlıklı ilerleyebilmesi için çalışmaya katılacağını bildiğiniz diğer kişilerle çalışma ile ilgili detaylı bilgi paylaşımında bulunmamanızı dileriz.

Katılımınız için tekrar teşekkür ederiz.

Appendix D: Appendix A: Ethics Committee Permission

T.C.
YEDİTEPE ÜNİVERSİTESİ REKTÖRLÜĞÜ

20.06.2022

Sayı : E.50532705-302.14.01-1308
Konu : Ayşe Kazaca Kurul Onayı

İLGİLİ MAKAMA

Üniversitemiz Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans Öğrencisi Ayşe Kazaca'nın, Dr. Öğr. Üyesi Ezgi Soncu Büyükişcan danışmanlığında gerçekleştireceği "Do Borderline Traits Make People More Sensitive? Relationship Between Borderline Personality Traits and Mentalization Capacity" başlıklı araştırmasının Beşeri Bilimler etik standartlarına uygunluğuna ilişkin Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurulu Onayı ekte sunulmuştur.

Gerekli iznin verilmesi hususunu bilgilerinize arz ve rica ederim.

İmza
Prof. Dr. Fatma Yeşim EKİNCİ
Rektör a.
Rektör Yardımcısı

Ek: Etik Kurul Onayı.pdf

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