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Validity and Reliability of the Turkish Version of the Binge Eating Scale*

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Studying binge eating is profoundly important for understanding its underlying mechanisms and developing effective interventions. Its measurement for non-clinical samples holds a pivotal role. The current study aims to examine the psychometric properties of the Turkish version of the Binge Eating Scale (BES) for the first time. The study included a non-clinical sample (N = 323) consisting of participants from 18 to 61 years old. Internal consistency, construct validity, and BES association with other measures were examined. We found a high internal consistency for the single-factor structure of the BES (α = .84). The internal consistency was weaker for the two-factor model, including cognitive/emotional and behavioral sub-dimensions (α = .75 and .67, *respectively*). Confirmatory factor analyses (CFAs) were conducted separately to test single-factor and two-factor structures of the BES. A single-factor structure measuring binge eating (BE) severity was accepted as the final version of the scale. BE was significantly related to body mass index (BMI), self-control, and body dissatisfaction in the expected directions. The current findings supported the single-factor structure. As a result, it has been shown that the Turkish version of the BES is a valid and reliable measurement tool.

Keywords: Binge Eating Scale, validity, reliability, adaptation, psychometric properties, Turkey, Turkish version

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Highlights:

- The Turkish version of the BES represents a single-factor structure measuring binge eating severity.
- The Turkish version of the BES could be a valid measurement tool.
- The Turkish version of the BES could be a reliable measurement tool.

Binge eating (BE) is a maladaptive health outcome for individuals both clinically diagnosed and those who have not yet exhibited severe enough behavior to be diagnosed (Mitchison et al., 2012). Such a health-related outcome was not defined as a specific disorder until the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychological Association [APA], 2013). It was added to the heading "Eating Disorders Not Otherwise Specified" in the previously revised version (APA, 2000). Moreover, BE was evaluated as an indicator of different eating disorders (e.g., bulimia nervosa; APA, 2000). However, since the latest version of the DSM criteria, this behavior has been assessed as the fundamental component of binge eating disorder (BED), which is a clinical case beyond being evaluated as a mere indicator. The DSM-5 defines BED (APA, 2013) criteria as "eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances" (p.350). Loss of control over eating is one of the main indicators of this disorder, and such behavior may be accompanied by feelings of shame and guilt (APA, 2013).

Eating disorders are not only associated with various comorbidities (Mohammadi et al., 2020) but are also highly associated with an increased risk of death and suicide (Crow et al., 2009; Sohn et al., 2023). The transition of BE behavior into a chronic disorder could lead to many negative physical (e.g., obesity, diabetes), psychological (e.g., life dissatisfaction, body dissatisfaction), and psychiatric (e.g., anxiety disorder, alcohol use disorder, various personality disorders) health outcomes (Citrome, 2019; Kessler et al., 2013; Mairs & Nicholls, 2016; Sonneville et al., 2013; Udo & Grilo, 2019). Such comorbidities may increase the severity and chronicity of BE and reduce the resistance to psychological and psychiatric treatment (Escrivá-Martinez et al., 2019).

BE is a behavior seen frequently in individuals not diagnosed with any disorder (Levallius et al., 2022). In addition, it was stated that the prevalence of this behavior would likely increase over time (Smink et al., 2014), and it is more common, especially among young individuals (Goldschmidt et al., 2015). Considering the frequency of cases progressing to a psychiatric diagnosis, according to the findings on BED prevalence, it was one of the most common (2.3%) eating disorders in women in a sample of adolescent individuals. The prevalence rate was lower among men (Smink et al., 2014). Similarly, in another study, the prevalence was around 3 percent in women, while this rate was about 1 percent in men (Sonneville et al., 2013).

According to another study conducted with a large sample representing the Australian population, BED was detected in 5.6% of the participants (Hay et al., 2015). In a more recent study on cardiovascular disease and obesity, BED was detected in 16 percent of the sample consisting of young individuals (Fox et al., 2021). Also, it was suggested that the incidence of BED may vary depending on the body mass index (BMI); the prevalence rates in slight obesity, obesity, and morbid obesity were reported as 1%, 3%, and 5%, respectively (Crossrow et al., 2016). There are more studies stating that BED is the most common eating disorder (e.g., Caldas et al., 2022; Mohammadi et al., 2020; Saunders et al., 2016; Marzilli et al., 2018). Furthermore, it was reported that one out of every 20 adults in a population without a clinical diagnosis had the BE problem (Mitchison et al., 2012). Thus, whether it is a clinical case or not, BE behavior has been identified as a serious problem, especially in adolescents and adults.

Studies on the prevalence of BED are rare in Turkey. For example, BED was detected in 1 percent of the participants based on the results of a two-stage study on the prevalence of eating disorders in adolescents assessed through both self-report and clinical interviews (Vardar & Erzengın, 2011). In another study conducted with the participation of 1,122 people in a city center in Turkey, eating disorders were detected in approximately 2 percent of the participants, while the prevalence of BED was reported as the most common disorder by approximately 1 percent (Semiz et al., 2012).

Negative outcomes of BE behavior and its prevalence are important reasons for the need for measurement tools to detect it. However, detecting BE could be challenging due to the accompanying emotions (e.g., shame, guilt) that may be difficult to express and possible difficulties in retrospective perceptions regarding the severity of episodes (Duarte et al., 2015). In this context, it was argued that the clearest conclusions about BE behavior could be formed through structured interviews conducted by clinical experts (e.g., Fairburn & Cooper, 1993). It should be noted that clinical interviews require more time and budget as well as equipped specialists. In this case, self-report scales, an alternative to detailed clinical interviews, could enable evaluations that require less time and budget in practice to assess BE tendencies. In that vein, the Binge Eating Scale (BES; Gormally et al., 1982) was suggested as a practical measurement tool, the validity and reliability of which were shown in children and adult samples (Cotter & Kelly, 2016; Freitas et al., 2006).

The BES was a frequently used, unique measurement tool, including emotional, cognitive, and behavioral indicators, aiming to measure the severity of BE behavior, especially when BED was not defined as a disorder before DSM-5 (Cotter & Kelly, 2016). Moreover, the BES is still one of the most widely used screening measures, especially for bariatric surgery candidates (Grupski et al., 2013).[1] Gormally et al. (1982) defined the psychometric properties of this scale through a two-factor structure and confirmed that structure in its validity and reliability study. Accordingly, eight items on the scale represented cognitive/emotional indicators of BE behavior, while the other eight represented behavioral

1 It has been emphasized as a highly recommended clinical practice to screen for the presence of BE severity before bariatric surgery (Hood et al., 2013).

indicators. However, it was reported that the BE could be measured as a single-factor structure rather than the two-factor structure in the previous adaptation studies of the scale (e.g., Brunault et al., 2016; Duarte et al., 2015).

Hood et al. (2013) examined the two-factor structure of the scale with confirmatory factor analysis in a sample of bariatric surgery candidates. As a result, the original two-factor structure was more compatible with the available data.[2] However, according to this result, item 16, an indicator of the emotional/cognitive dimension in the original scale, was loaded as an indicator of the behavioral dimension. In another study aiming to expand and repeat the findings of Hood et al. (2013), Marek et al. (2015) examined the psychometric properties of the BES with the participation of bariatric surgery candidates (24 percent of the participants were also diagnosed with BED). As a result, the researchers suggested there was a validity problem in the two-factor structure of the scale, and it should be used as a single-factor scale.

Subsequently, in an adaptation study, Imperatori et al. (2016) examined the psychometric properties of the Italian version of the BES. They compared the single-factor and two-factor structure of the scale through the alternative model test. The researchers emphasized that considering the sub-factors (i.e., cognitive/emotional and behavioral) would not provide useful information and recommended that the scores obtained from the scale be calculated to represent a single factor. Similarly, in the validity and reliability study of the Malay form of the BES, the final version of the scale did not reflect the original factor structure of the scale, although the two-factor structure better fitted with the data (Robert et al., 2013). In addition, it was reported that the fit indices of the single-factor structure were perfect in the Malay version of the scale. As a result, the researchers recommended the single-factor structure for the Malay version of the BES (see Robert et al., 2013). Parallel to this, it was stated that the single-factor structure best reflected the psychometric properties of the scale for the Portuguese (Duarte et al., 2015), French (Brunault et al., 2016), and Spanish (Escrivá-Martinez et al., 2019) forms of the scale.

Purpose of the Current Study

Studies on the psychometric properties of this scale are rare in non-clinical samples (Duarte et al., 2015). In the current study, the reliability and validity of the Turkish version of the BES were aimed to be examined in a sample of individuals who did not have any clinical diagnosis. Although the existing body of knowledge recommends the single-factor structure of the scale, an alternative model, in which the sub-dimensions existed separately, was also tested by confirmatory factor analysis. In addition, BES's association with other constructs (e.g., self-control, body dissatisfaction, and BMI) was examined through bivariate relationships. The Turkish adaptation of the study would enable researchers to use the scale in further research aiming to monitor binge eating symptomology and to conduct community-based studies held in samples from Turkey.

2 The research conducted by Hood et al. (2013) showed that the model in which the BES was tested as a single-factor construct also fitted adequately with the available data, χ^2 (104) = 298.78, CFI = .96, RMSEA = .06.

Method

Participants

Participants were reached through a convenience sampling strategy. The study was announced on the social media accounts of researchers and in two different universities in Turkey. Individuals older than 18 years of age and not diagnosed with any clinical disorder were invited as a criterion for participation in the study. Students who met the inclusion criteria participated in the research in exchange for course credit. The minimum number of participants required for a confirmatory factor analysis with .90 expected comparative fit index (CFI) of 16 items and a single factor was found to be 112 (Arifin, 2024).

The data of a participant who has type 1 diabetes were not included in the analysis. The final sample of the study consists of 323 respondents (N_{women} = 166; 51.4%) 18−61 years of age.[3] Twenty-seven respondents were reached via the online survey shared on social media. The majority of the sample consisted of university students (primary school [6.5%], high school [17.6%], university students [44%], university degree [15.2%], graduate student [11.1%], graduate degree [5.6%]). Based on height and weight reported by the respondents, more than half of the participants' BMI was normal (underweight [6.5%], obese [9.6%], overweight [28.2%], and normal [55.7%]).[4]

Measures

Binge Eating Scale (BES)

The English form of BES developed by Gormally et al. (1982) consists of 16 items. Eight of these items aim to measure cognitive/emotional (e.g., guilt, loss of control) indicators/symptoms of BE, while the other eight aim to measure behavioral (e.g., eating fast, eating a lot) indicators/symptoms. Each measurement item contains three or four alternative answers with scores ranging from 0−3 to detect BE severity. Participants are asked to mark the option that best describes them. The Turkish form of the scale and the scoring were shown in the Appendix. Accordingly, the total score that can be obtained from the scale ranges from 0 to 46, and the high score indicates the severity of the BE. According to these scores, individuals can be divided into three groups (Marcus et al., 1985). Those with a total score of 17 and lower can be grouped as "no or minimal BE", those between 18 and 26 points as "mild to moderate BE", and those with 27 points and above as "severe BE." The reliability coefficient was reported as .85 in the original study (Gormally et al., 1982).[5] In addition, the reliability coefficient of the scale was generally found to be above .80 in the previous studies (Cotter & Kelly, 2016).

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3 Among the participants, 148 couples (296 participants) participated in the study with their romantic partners (e.g., dating, married or cohabiting).

4 Given that there were participants with varying BMIs, all analyses were rerun with two subsamples, i.e., *participants with normal BMI* and *participants reporting BMI exceeding the normal BMI*. Considering the frequency of each group, the obese and overweight groups were combined into one group. Reliability results were similar in the two subsamples compared to the entire sample. The two subsamples differed in factor analysis results compared to the whole sample. The single-factor or two-factor structures did not adequately fit the model. Correlational findings were similar in the two subsamples compared to the entire sample. All those findings were reported in the supplementary material document in detail. The document is available at the following link:

5 In the original scale study, although the researchers pointed to a two-factor structure, they only reported a reliability coefficient of a single-factor structure (Gormally et al., 1982, p. 50).

Brief Self-Control Scale (BSCS)

Previous studies suggested that higher self-control would be associated with lower BE tendency (e.g., Horwath et al., 2020; Waltmann et al., 2021). Thus, we included the Brief Self-Control Scale (BSCS). The scale developed by Tangney et al. (2004) consists of 13 items (e.g., "I *am good at resisting temptation*.") representing a single factor. This scale was found reliable in two studies conducted by the authors (Cronbach's alpha = .83 and .85, respectively). Participants responded based on a Likert-type scale ranging from 1 (totally wrong) to 5 (totally true). There are reverse-coded items in the scale; those scoring higher on this scale refer to having more self-control. The Turkish adaptation study of BSCS was conducted by Nebioglu et al. (2012). The researchers stated that the single-factor structure of the scale was reliable (Cronbach's alpha = .83). In the current study, the scale was reliable (Cronbach's alpha = .77; McDonald's omega = .79).

Body Dissatisfaction Scale (BDS)

Previous work showed that individuals who reported more body dissatisfaction were found to show more severe BE (e.g., Cella et al., 2021; Chen et al., 2021). It is one of the subscales of the Eating Disorder Inventory-1 (EDI-1) developed by Garner et al. (1983) and consists of nine items (e.g., "*I feel satisfied with the shape of my body*"). Participants responded based on a Likert-type scale ranging from 1 (totally disagree) to 5 (totally agree). There are reverse-coded items; higher scores indicate more body dissatisfaction. Since there is no Turkish adaptation study for the EDI-1, the Turkish translation of the sub-scale was completed following the same translation process as described for the BES in the procedure section. In the current study, BDS was reliable (Cronbach's alpha = .85; McDonald's omega = .84).

Demographic Variables

Body mass index (BMI) was calculated by dividing the weight (in kilograms) by the square of participants' height (in meters) (World Health Organization, 2000) gathered based on self-report answers. Previous findings showed that higher BMI was related to higher BE scores (e.g., Duarte et al., 2015). Thus, BMI was used to test the validity of the BES. In addition, variables with a relatively more inconsistent relationship with BE, such as gender, age, education level, and relationship duration, were also included in the correlation analysis.

Procedure

The current study is part of a more comprehensive project. Having been approved by the ethical committee, the research process was started. The original English form of the BES, including its instructions and items, was translated into Turkish via the back-translation method. In the first phase of the translation, the Turkish form of the scale was generated independently by two researchers whose native language is Turkish and who have an advanced English proficiency level. The translations were compared, and necessary modifications were made to ensure consensus among the researchers. Then, the form was re-examined by another researcher, a native Turkish speaker with an advanced level of English, via back-translation. There was no difference of opinion between the three researchers for the final version of the translation. Finally, five participants whose data were not included in the analyses filled out the entire questionnaire to give feedback. As a result, there was no considerable change in the form.

The survey form was delivered to the students who participated in the research through the announcement at the university in a sealed envelope signed by the researcher. Since the main goal of the whole project was to collect data from romantic couples, those who received the questionnaire declared that they could participate with their romantic partners. Other than themselves, some received more than one envelope to deliver the questionnaire to other volunteers who could participate together with their partners. Participants who received the questionnaire were given one week to return the form. The data of the participants who submitted the questionnaire in a different way other than the

signed envelope and those who exceeded one week were excluded from the analysis. The exact form was also announced via social media to reach more participants. The survey link was activated for one week.

Analysis Plan

First, the reliability of both scales, i.e., single-factor and two-factor, was examined based on Cronbach's alpha and McDonald's omega coefficients and corrected item-total correlations. A reliability coefficient higher than .70 and a corrected item-total correlation coefficient higher than .30 were accepted as satisfactory. Subsequently, the single-factor and two-factor structures of the BES were tested via confirmatory factor analyses (CFAs). The following goodness of the fit indices was interpreted to decide the best factor structure: Comparative Fit Index (CFI), Standardized Root Mean Square (SRMR), and Root Mean Square Error of Approximation (RMSEA). A CFI value equal to or higher than .90, and SRMR and RMSEA values equal to or less than .08 are accepted as indicators of adequate model fit (Hu & Bentler, 1999). Additionally, possible modification indices were examined after the CFAs. CFA results of the two models, i.e., single-factor BES and two-factor BES, were compared based on two interpretations. First, a greater number of Akaike Information Criterion (AIC) was an indicator of a worse model fit (Hu & Bentler, 1999). Second, Cheung and Rensvold (2002) suggested that model fit differences could be negligible considering a cut-off point of .01 for a CFI difference between two models. Next, descriptive statistics and bivariate correlations based on Pearson's *r* among the variables were examined. The main aim of examining the bivariate relationships was to test the scale's validity. Analyses were conducted using SPSS 20 and Mplus 7 software.

Results

Reliability

Reliability coefficients for each factor structure were separately examined. The single-factor structure was reliable (Cronbach's alpha = .84; McDonald's omega = .85). The reliability coefficients for the two-factor structure's sub-dimensions (i.e., cognitive/emotional and behavioral) based on alpha values were .75 and .67, respectively (McDonald's omega values = .76, .69, respectively). There was no increase in the reliability coefficient due to deleting any item from the scale in both factor structures.

Factor Analysis

CFA on single factor structure showed that the model did not adequately fit with the data, [(χ^2 (104) = 247.90, p <.001), CFI = .87, SRMR = .05, RMSEA = .07]. Having examined the modification indices, an error covariance (between item 14 and item 6; r = .34, p <.001) that could significantly improve the model fit was added to the model. After adding that error covariance to the model, the model adequately fitted with the data, [(χ^2 (103) = 211.22, p <.001), CFI = .90, SRMR = .05, RMSEA = .06, AIC = 10644.576].[6] Likewise, CFA on two-factor

6 The same error covariance between those items was added to improve the model fit in a previous adaptation study conducted by Duarte et al. (2015). Those two items (e.g., "I don't feel any guilt or self-hate after I overeat" and "I don't think much about trying to control unwanted eating urges") point out the same theoretical sub-construct related to cognitive/

structure showed that the model did not adequately fit with the data, [(χ^2 (103) = 245.20, p <.001), CFI = .87, SRMR = .05, RMSEA = .07]. After examining the modification indices, the same error covariance in the single factor model (i.e., between item 14 and item 6) was added to improve the model fit, [(χ^2 (102) = 207.48, p <.001), CFI = .90, SRMR = .05, RMSEA = .06, AIC = 10646.312]. In the final version of both models, the CFI difference was not larger than the cut-off point of .01 (ΔCFI = .003), suggesting a similar model fit across the two different factor structures. However, the single-factor model had a lower AIC value compared to the two-factor structure, which could indicate a slightly better model fit.

Based on the existing literature, a better reliability coefficient, and a lower AIC value, the single-factor structure of the scale was accepted as the final version of the scale, and the remaining analyses were conducted using this structure. As can be seen in Table 1, standardized factor loadings of the single-factor scale ranged from .35 to .64, and corrected item-total correlations ranged from .32 to .56.

Table 1
Single-Factor BES

Item	SFL	CITC
1	0.353	0.347
2	0.520	0.473
3	0.598	0.531
4	0.360	0.336
5	0.480	0.415
6	0.354	0.360
7	0.535	0.500
8	0.600	0.535
9	0.556	0.523
10	0.636	0.563
11	0.589	0.529
12	0.346	0.317
13	0.354	0.329
14	0.511	0.493
15	0.601	0.526
16	0.557	0.517

Note. SFL = Standardized Factor Loadings;
CITC = Corrected Item-Total Correlation.

BES Association with Other Measures

Descriptive statistics and bivariate relationships among the variables were shown in Table 2 and Table 3, respectively. Gender, age, education level,

emotional processes (i.e., feeling and thinking) of binge eating. Therefore, parallel to the adaptation of Duarte et al. (2015), additional error covariance would theoretically be adequate in the current study.

and relationship duration were not significantly associated with BE severity (*ps*> .05). There was a positive and moderate level of relationship between BMI and BE severity (r = .27, p <.001). Likewise, there was a positive and moderate level of relationship between body dissatisfaction and BE severity (r = .45, p <.001). The relationship between self-control and BE severity was negative at a moderate level (r = –.42, p <.001). Thus, higher BMI, lower self-control, and greater body dissatisfaction could be significantly related to more severe BE. It could be concluded that the Turkish form of the BES showed good validity.[7]

Table 2.
Descriptive Statistics of the Continuous Variables

Variables	*M*	*SD*	*Min.*	Max.	Skewness	Kurtosis
Binge eating	9.51	6.82	0	34	0.93	0.71
Age	29.61	11.04	18	61	1.06	0.02
BMI	23.97	4.19	16.16	40.57	0.58	0.02
Relationship Duration	91.56	111.8	3	444	1.35	0.57
Self-control	42.04	7.93	20	64	0.09	-0.16
Body dissatisfaction	2.56	0.83	1	5	0.28	-0.49

Note. The duration of the relationship was answered in months.

Table 3.
Bivariate Relationships among Variables

		1	2	3	4	5	6	7
1	Binge Eating							
2	Gender	0.081						
3	Age	-0.077	0.108					
4	BMI	0.273**	0.420**	0.493**				
5	Education	-0.058	0.025	-0.178*	-0.157*			
6	Relationship duration	-0.063	0.015	0.881**	0.421**	-0.346**		
7	Self-control	-0.424**	-0.015	0.275**	0.034	-0.054	0.225**	
8	Body dissatisfaction	0.445**	-0.172*	0.088	0.236**	-0.022	-0.061	-0.352**

Note. Correlations were reported based on Pearson's *r*. Gender: Women = 0, Men = 1. * p <.01, ** p < .001.

7 Univariate variance analyses showed that self-control and body dissatisfaction scores significantly differed across the three categories of binge eating severity. All pairwise comparisons were significantly different for the two variables (p values <0.05). More specifically, when the severity of BE symptomology increased, participants reported less self-control and greater body dissatisfaction. Similarly, the main effect of the group variable was significant on BMI. Pairwise comparisons showed that the BMI of participants with severe BE symptomology was significantly greater than the ones with no or minimal BE symptomology (p = 0.022). The remaining pairwise comparisons were not significant for BMI. Overall, ANOVA findings were consistent with the correlation results.

Discussion

The BES is a frequently used measurement that includes attitudinal and behavioral indicators of BE (Grupski et al., 2013). Nevertheless, research is scarce focusing on its psychometric properties (Escrivá-Martinez et al., 2019). This scale, which was originally developed in English by Gormally et al. (1982), was adapted in different languages (French, Spanish, Italian, Malay, and Portuguese) in the existing body of knowledge (Brunault et al., 2016; Escrivá-Martinez et al., 2019; Imperatori et al., 2016; Robert et al., 2013; Duarte et al., 2015). In the present study, the factor structure and psychometric properties of the Turkish version of the BES were examined for the first time.

The original scale was developed based on two factors: cognitive/emotional and behavioral indicators of BE (Gormally et al., 1982). Although the single-factor and two-factor structures of the scale showed perfect model fit in the previous studies, it was recommended to be used as a single-factor scale (e.g., Escrivá-Martinez et al., 2019; Imperatori et al., 2016; Robert et al., 2013). To be noted, however, alternative model comparison for the scale was rarely attempted to test in a given sample. As one of those rare attempts in the current study, statistical findings on the two different factor structures were slightly different despite being adequately fitted with the available data. As a result of the recommendations in the literature and statistical findings favoring the single-factor structure, we suggest that the Turkish version of the BES should be used in a way that represents a single-factor structure.

The scale showed a high internal consistency parallel to the previous studies involving non-clinical samples (e.g., Duarte et al., 2015; Gordon et al., 2012). Moreover, factor loadings of the items and item-total correlation ranged from moderate to high coefficients, strengthening the validity and reliability of the scale. Yet, internal consistency regarding the two-factor structure of the scale was found to be weaker, especially for the behavioral dimension. Similar findings were reported in the literature, and it was highly emphasized that the two-factor structure of the BES should not be used due to statistical and practical reasons (e.g., Marek et al., 2015; Robert et al., 2013).

BMI (e.g., Duarte et al., 2015), self-control (e.g., Horwath et al., 2020; Waltmann et al., 2021), and body dissatisfaction (e.g., Cella et al., 2021; Chen et al., 2021) were found to be related to BE in the expected directions consistent with the many previous studies. Such findings support the validity of the scale. In the existing body of knowledge, there was a less clear picture regarding the relationship between the other demographic variables (gender, age, education level, and relationship duration) and BE. Statistically, non-significant links between those variables and BE would be another indicator of scale validity.

However, there is a substantial number of findings suggesting that women may be more likely to show BE tendency (e.g., Escrivá-Martinez et al., 2019) or be diagnosed with BED (e.g., Smink et al., 2014) compared to men. There could be at least one explanation for this inconsistency in the present study. As stated in the method section, most respondents participated in the research with

their romantic partners. Relationship science indicates that dyadic data collected from romantic partners could be highly related in terms of relationship dynamics and health outcomes (e.g., Pietromonaco & Powers, 2015; Reis et al., 2002). In this context, it may be an expected result that such a gender difference was not found, assuming that a health-related outcome (i.e., BE scores) of the romantic partners may have already been related to one another.

It was suggested that the BES could be used in both clinical and non-clinical samples (e.g., Černelič-Bizjak & Guiné, 2022; Imperatori et al., 2020). It was found to be a valid and reliable tool for assessing clinical cases such as obesity and BED (e.g., Dezhkam et al., 2009; Hood et al., 2013). To test the practicality of the BES, the researchers compared the scale with other diagnostic tools requiring more budget, time, and expert mental health professionals. For instance, Celio et al. (2004) conducted a study, including a sample diagnosed with BED, to compare the BES to the Eating Disorders Examination Inventory (Fairburn and Cooper, 1993). In another study, consisting of a sample of women with obesity diagnosis, the BES was compared to structured clinical interviews (Freitas et al., 2006). In both studies, the authors confirmed that the BES could be used as a practical screening tool to distinguish the clinical samples during the assessment process.

Over and above, such a brief and practical scale could be used to measure BE symptomology before interventions or during follow-up care. For instance, BES was used to measure the severity of BE symptomology in a study examining the effect of an intervention on women diagnosed with BED (Duarte et al., 2017). Similarly, in another intervention focusing on the effect of emotion-focused therapy on BED, the scale was used to measure BE psychopathology during both the assessment and follow-up period (Glisenti et al., 2018). Therefore, the BES could be an understandable and practical assessment tool in pre-surgical treatment recommendations, follow-up care, and community-based intervention programs held in samples from Turkey.

Currently, the scale has rather been suggested as a brief screening tool to evaluate BE severity in non-clinical samples (Han & Pistole, 2014; Nicoli & Junior, 2011). Thus, it could be recommended as a useful tool in monitoring intervention programs and treatment outcomes, as Gormally et al. (1982) carried out an adaptation study with individuals with overweight and obesity problems. Its validity and reliability were demonstrated in the sample of clinical, non-clinical, and university students, especially in the USA. It is recommended for initial screening rather than a diagnostic tool (Cotter & Kelly, 2016). As a result of the current adaptation study, we argue that confidence in using the Turkish version of the scale could be encouraging, especially in non-clinical samples. However, future studies are suggested comparing clinical and non-clinical samples through the BES.

The current study should be evaluated with caution due to several limitations. First, the study's cross-sectional nature may bring about hesitancy regarding the test-retest reliability of the scale. Also, the nature of the sampling methodology is a weakness of the study, disabling us to generalize the findings

to clinical samples. In addition, most of the respondents participated in the current study with their romantic partners, which could limit the generalizability of the findings. Future studies should replicate the findings through diverse samples of participants from varying demographic backgrounds (e.g., age, romantic status, educational status). Social desirability may be another possible threat to the reliability of the findings. In particular, self-report assessment of height and weight to calculate BMI may lead to underestimation of that score. Nevertheless, the psychometric properties of the Turkish form of BES showed valid and reliable results in a Turkish sample of young and adult individuals. In addition, a power analysis showed that the current sample size could afford to conduct such an analysis.

Conclusion

Overall, the current paper examined the Turkish adaptation of the Binge Eating Scale. Parallel to the previous findings, the single-factor structure of the scale was confirmed and found to be reliable. Therefore, the Turkish version can be helpful in monitoring BE symptomology before interventions or during follow-up care held in samples from Turkey.

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Valjanost i pouzdanost turske verzije skale za prejedanje

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Proučavanje prejedanja je izuzetno važno za razumevanje njegovih osnovnih mehanizama i razvoj efikasnih intervencija. Njegovo merenje za nekliničke uzorke ima ključnu ulogu. Sadašnja studija ima za cilj da po prvi put ispita psihometrijske osobine turske verzije Skale prekomernog jedenja (BES). Studija je obuhvatila neklinički uzorak (N = 323) koji su činili učesnici od 18 do 61 godine. Ispitivana je interna konzistentnost, konstruktivna validnost i povezanost BES-a sa drugim merama. Pronašli smo visoku pouzdanost interne konzistencije za jednofaktorsku strukturu BES-a (a = 0,84). Pouzdanost interne konzistencije je bila slabija za dvofaktorski model, uključujući kognitivne/emocionalne i bihevioralne poddimenzije (a = 0,75 i 0,67, respektivno). Potvrdne faktorske analize (CFA) su sprovedene odvojeno da bi se testirale jednofaktorske i dvofaktorske strukture BES-a. Jednofaktorska struktura koja meri ozbiljnost prejedanja (BE) prihvaćena je kao konačna verzija skale. BE je bio značajno povezan sa indeksom telesne mase (BMI), samokontrolom i nezadovoljstvom telom u očekivanim pravcima. Nalazi podržavaju jednofaktorsku strukturu. Kao rezultat toga, pokazalo se da je turska verzija BES validan i pouzdan alat za merenje.

Ključne reči: Binge Eating Scale, validnost, pouzdanost, adaptacija, psihometrijska svojstva, Turska, turska verzija

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APPENDIX
Turkish version of the BES items with Turkish instruction.

Note: Respondents are required to select one option for each of the statements. The numbers in parentheses represent the scoring/binge eating severity for that option. This scoring relied on the original scale invented by Gormally et al. (1982).

Sayın Katılımcı,

Sizden aşağıda gruplar halinde numaralandırılmış ifadeleri dikkatlice okumanız ve yeme davranışlarınızı kontrol ederken deneyimlediğiniz problemleri en iyi tanımlayan ifadeyi, her soru için ayrı ayrı işaretlemeniz istenmektedir.

1.

a) Başkaları ile birlikteyken kilom ve vücut ölçülerim hakkında pek düşünmem. **(0)**
b) Başkalarına nasıl göründüğümü umursarım, ama bu genellikle kendimle ilgili hayal kırıklığı hissettirmez. **(0)**
c) Beni hayal kırıklığına uğratan görünüşümden ve kilomdan utanırım. **(1)**
d) Kilom üzerinde çok düşündüğümü hissederim ve sıklıkla kendimden utanır ve iğrenirim. Bu öz-farkındalığım nedeniyle insanlarla iletişim kurmaktan kaçınırım. **(3)**

2.

a) Doğru şekilde, yavaş yemek ile ilgili bir zorluk yaşamam. **(0)**
b) Yemekleri silip süpürüyor görünsem bile sonunda çok yemekten tıkanmışhissetmem. **(1)**
c) Hızlı yemek yemeye eğilimli olduğum zamanların sonrasında rahatsız edici derecede tok hissederim. **(2)**
d) Yemeği çiğnemeden yutma gibi bir alışkanlığım vardır. Böyle olduğunda genellikle çok yemiş olduğum için rahatsız edici derecede tıka basa dolu hissederim. **(3)**

3.

a) İstediğim zaman yemek yeme dürtülerimi kontrol edebilirim. **(0)**
b) Yemek yememi kontrol ederken ortalama bir insandan daha fazla başarısızlığa uğradığımı hissederim. **(1)**
c) Yemek yeme dürtülerimi kontrol etmek söz konusu olduğunda, kendimi son derece çaresiz hissederim. **(3)**
d) Beslenmemi kontrol etmekte çok çaresiz hissettiğim için, kontrolü ele geçirmeye çalışırken tamamıyla umutsuz olurum. **(3)**

4.

a) Sıkıldığım zamanlarda yemek yeme alışkanlığım yoktur. **(0)**
b) Sıkıldığımda bazen yemek yerim, ama genellikle kendimi meşgul etmeyi ve yemeği aklımdan uzaklaştırmayı başarabilirim. **(0)**

c) Sıkıldığımda yemek yemek düzenli bir alışkanlığımdır, ama ara sıra başka aktiviteleri aklımdan yemek yemeyi uzaklaştırmak için kullanabilirim. **(0)**
d) Sıkıldığımda yemek yemek değişmez bir alışkanlığımdır. Hiçbir şey bu alışkanlığımı kırmama yardım edebilirmiş gibi gelmiyor. **(2)**

5.

a) Genelde acıktığım zaman bir şey yerim. **(0)**
b) Ara sıra, gerçekten aç olmamama rağmen içgüdüsel (gayri ihtiyari) olarak bir şeyler yerim. **(1)**
c) Fiziksel olarak besine ihtiyacım olmadığında bile açlık hissini gidermek için gerçekten keyif almayacağım şekilde yemek gibi düzenli bir alışkanlığım var. **(2)**
d) Fiziksel olarak aç olmadığımda bile sandviç gibi ağzımı dolduracak bir şey yediğimde geçecekmiş gibi gelen bir açlık hissim olur. Bazen bu açlığımı geçirmek için yemek yedikten sonra kilo almamak için yediğim yemeği kusarım. **(3)**

6.

a) Aşırı yedikten sonra suçluluk hissetmem ya da kendimden nefret etmem. **(0)**
b) Ara sıra, aşırı yedikten sonra suçluluk hissederim ya da kendimden nefret ederim. **(1)**
c) Neredeyse her zaman aşırı yedikten sonra ağır suçluluk hissederim ya da kendimden çok nefret ederim. **(3)**

7.

a) Aşırı yediğim dönemlerden sonra bile diyet yaparken beslenmem üzerindeki tüm kontrolümü kaybetmem. **(0)**
b) Diyetteyken yasaklı yiyecek yediğim bazı zamanlarda elime yüzüme bulaştırdığımı hissedip daha fazla yerim. **(2)**
c) Diyetteyken çok yediğim zamanlarda sık sık kendime "şimdi her şeyi batırdım, battı balık yan gider" deme alışkanlığım vardır. Böyle olunca daha fazla yerim. **(3)**
d) Katı diyetlere başlama gibi bir adetim var ama fazla yiyerek bu diyetleri bozarım. Hayat tarzım, ya kendime ziyafet çekecek ya da kıtlıktaymış gibi davranacak şekildedir. **(3)**

8.

a) Nadiren, rahatsız edecek kadar çok yerim. **(0)**
b) Neredeyse ayda bir kez, yedikten sonra "tıka basa doymuş" gibi hissedecek miktarda yerim. **(1)**
c) Ay içinde, düzenli olarak; ya yemek vakti ya da atıştırmalık olarak çok fazla yemek yediğim zamanlar olur. **(2)**
d) Devamlı olarak yedikten sonra çok fazla rahatsız hissedecek kadar, bazen de midem bulanacak kadar fazla yemek yerim. **(3)**

9.

a) Kalori alım düzeyim düzenlidir, ne çok yüksek ne de çok az olur. **(0)**
b) Bazen, çok fazla yedikten sonra, aldığım fazla kaloriyi dengelemeye yetmeyecek kadar olsa da, kalori alımını düşürmeye çalışırım. **(1)**
c) Geceleri devamlı çok yeme gibi bir alışkanlığım var. Görünen o ki, sabahları aç kalmama akşamları ise çok yeme gibi bir alışkanlığım var. **(2)**
d) Kendimi haftalarca gerçekten aç bıraktığım zamanlar oluyor. Bu zaman aralığını çok fazla yediğim zamanlar takip ediyor. Görünen o ki; kendime ziyafet çekecek ya da kıtlıktaymış gibi davranacak şekilde yaşıyorum. **(3)**

10.

a) Genelde, yemek yemeyi istediğim zaman bırakabilirim. Sınırımı biliyorum. **(0)**
b) Bazen kontrol edemediğim bir yemek yeme dürtüsü yaşıyorum. **(1)**
c) Sık sık kontrol edemediğim yemek yeme isteği yaşıyorum, ama diğer zamanlarda bu yemek yeme isteğimi kontrol edebiliyorum. **(2)**
d) Yemek yeme isteğimi kontrol etme kabiliyetimin olmadığını hissediyorum. Yemek yemeyi kendi isteğimle bırakamamaktan korkuyorum. **(3)**

11.

a) Tok hissettiğim zamanlarda yemek yemeyi bırakmada sorun yaşamıyorum. **(0)**
b) Tok hissettiğimde genellikle yemeyi bırakabilirim ancak ara sıra aşırı yemek rahatsız edici derecede tıkanmış hissettiriyor. **(1)**
c) Bir kere başladıktan sonra yemek yemeyi bırakmakta sorun yaşarım ve genellikle bir öğün yedikten sonra tıkanmışçasına rahatsız hissederim. **(2)**
d) İstediğim zaman yemek yemeyi bırakmakta sorun yaşadığım için, bazen tıkanmışlık hissimi gidermek için kusarım. **(3)**

12.

a) Hem başkalarıyla beraberken (aile, sosyal çevre) hem de yalnızken aynı miktarda yeme eğilimindeyim. **(0)**
b) Bazen başkalarıyla birlikteyken istediğim kadar çok yemek yemem, çünkü yemek yemem konusunda kendimi bilirim. **(1)**
c) Diğer insanlar varken sık sık az miktarda yemek yerim, çünkü yemek yememle ilgili çok utanırım. **(2)**
d) Aşırı yemek yememden o kadar utanırım ki, yemek yemek için kimsenin beni görmeyeceğini bildiğim zamanları seçerim. **(3)**

13.

a) Nadiren yemek arasında atıştırarak günde 3 öğün yemek yerim. **(0)**
b) Günde 3 öğün yemek yerim ve genelde öğün aralarında atıştırırım. **(0)**
c) Çok fazla atıştırdığım zamanlarda düzenli öğünlerimi atlama alışkanlığım vardır. **(2)**
d) Öğünlerimi planlamadan devamlı yemek yediğim belirli dönemler vardır. **(3)**

14.

a) İstenmeyen yemek yeme dürtülerimi kontrol etmeye çalışmak üzerine çok düşünmem. **(0)**

b) En azından bazı zamanlarda, zihnimin yeme dürtülerimi kontrol etmeye çalışmakla meşgul olduğunu hissederim. **(1)**

c) Sık sık, ne kadar çok yediğimi ya da daha fazla yememeye çalıştığımı düşünmeye çok zaman harcarım. **(2)**

d) Uyanık olduğum zamanın çoğunda yemek yemek ya da yememek ile ilgili düşüncelerle meşgulmüşüm gibi gelir. Sürekli yemek yememek için mücadele ediyormuş gibi hissederim. **(3)**

15.

a) Yemekler üzerine çok düşünmem. **(0)**

b) Doymak bilmez bir iştahım vardır ama kısa sürede geçer. **(1)**

c) Yemekten başka hiçbir şey düşünemediğim günler vardır. **(2)**

d) Günlerimin çoğu yemekle ilgili düşüncelerle meşgulmüş gibi gelir. Yemek için yaşadığımı hissederim. **(3)**

16.

a) Genellikle aç olup olmadığımı bilirim. Kendimi doyurmak için yeteri kadar porsiyon alırım. **(0)**

b) Ara sıra açlığımı bildiğimden emin olamam. Böyle zamanlarda kendimi doyurmak için ne kadar yemek yemem gerektiğini anlamam zordur. **(1)**

c) Ne kadar kalori yemem gerektiğini bilsem bile, benim için normal miktar yiyeceğin ne kadar olduğuna dair bir fikrim yoktur. **(2)**