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Validity of the Eating Disorder Examination Questionnaire (EDE-Q) in screening for eating disorders in community samples

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Abstract

In order to examine the concurrent and criterion validity of the questionnaire version of the Eating Disorders Examination (EDE-Q), self-report and interview formats were administered to a community sample of women aged 18–45 ($n = 208$). Correlations between EDE-Q and EDE subscales ranged from 0.68 for Eating Concern to 0.78 for Shape Concern. Scores on the EDE-Q were significantly higher than those of the EDE for all subscales, with the mean difference ranging from 0.25 for Restraint to 0.85 for Shape Concern. Frequency of both objective bulimic episodes (OBEs) and subjective bulimic episodes (SBEs) was significantly correlated between measures. Chance-corrected agreement between EDE-Q and EDE ratings of the presence of OBEs was fair, while that for SBEs was poor. Receiver operating characteristic (ROC) analysis, based on a sample of 13 cases, indicated that a score of 2.3 on the global scale of the EDE-Q in conjunction with the occurrence of any OBEs and/or use of exercise as a means of weight control, yielded optimal validity coefficients (sensitivity = 0.83, specificity = 0.96, positive predictive value = 0.56). A stepwise discriminant function analysis yielded eight EDE-Q items which best distinguished cases from non-cases, including frequency of OBEs, use of exercise as a means of weight control, use of self-induced vomiting, use of laxatives and guilt about eating. The EDE-Q has good concurrent validity and acceptable criterion validity. The measure appears well-suited to use in prospective epidemiological studies.

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1. Introduction

It is generally accepted that assessment of the specific psychopathology of eating-disordered behaviour is best achieved through the administration of a structured or semi-structured interview by clinicians or by trained lay interviewers (Garner, 2002). Frequently, however, constraints on time and resources encourage the use of self-report measures. For example in epidemiological studies of low-prevalence psychiatric disorders, it is usually not possible to conduct interview assessment with the total sample. For this reason the use of a two-phase design, in which interview assessment is conducted only with probable cases identified on the basis of a self-report measure, is often employed in such studies (Dunn, Pickles, Tansella, & Vazquez-Barquero, 1999).

Among self-report measures of eating-disordered behaviour, the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979) has been widely employed as an outcome measure in clinical and research settings. A 26-item version of the original 40-item scale (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982) has also frequently been used to detect probable cases of eating disorders in general population surveys. However, the measure was originally developed to assess the specific behaviours and attitudes of anorexia nervosa (AN) patients, and its validity as a 'case-finding' instrument has frequently not been supported (Patton & Szmukler, 1995). An additional shortcoming of the EAT is that an omnibus score is derived at the expense of dimensional information concerning particular symptoms (Anderson & Williamson, 2002). The Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983), arguably the most comprehensive self-report measure of eating disorder psychopathology, has also been widely used, but it is too long for use as a screening instrument and it has not been validated for this purpose (Garner, 1991).

In general, the use as case-finding instruments of measures developed for use in clinical samples is problematic, since the characteristics of individuals identified as cases in general population surveys may differ from those of individuals presenting to services. For example, items addressing the occurrence of extreme methods of weight control, such as self-induced vomiting and laxative misuse, may be of limited use in community samples, because the prevalence of such behaviours is much lower (Garfinkel et al., 1995). Similarly, the extreme dietary restriction and very low body weights characteristic of AN patients are rarely encountered in general population surveys (Walters & Kendler, 1995). Instruments such as the EAT may therefore not be expected to perform well in detecting the relatively more common eating disorders, such as BED and partial-syndrome cases of AN and BN (Hay, Marley, & Lemar, 1998).

A promising alternative to the EAT is the self-report version of the Eating Disorders Examination (EDE-Q; Fairburn & Beglin, 1994), a 36-item questionnaire derived from and scored in the same way as the interview schedule (EDE; Fairburn & Cooper, 1993). The EDE is widely regarded as the instrument of choice for the assessment and diagnosis of DSM-IV eating disorders (Garner, 2002). The EDE-Q provides a similarly comprehensive assessment of the specific psychopathology of eating-disordered behaviour in a relatively brief self-report format. Studies of the validity of the EDE-Q have demonstrated a high level of agreement between the EDE-Q and EDE in assessing the core attitudinal features of eating disorder psychopathology in the general population (Fairburn & Beglin, 1994), among female substance abusers (Black & Wilson, 1996), and in clinical samples of both bulimia nervosa (BN) and binge eating disorder

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