Anderson, D. A., Schaumberg, K., Reilly, E. E., & Anderson, L. M. (2015). Research tools for assessing eating disorders. In L. Smolak & M. P. Levine (Eds.), The Wiley handbook of eating disorders (Vol. 2, pp. 537–554). Chichester, UK: John Wiley & Sons.

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Research Tools for Assessing Eating Disorders

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Assessment in a research context can be challenging. Research studies, particularly treatment outcome studies, are costly and involve enormous amounts of time and effort, and decisions about how and when to conduct assessments can have a significant impact on the conclusions that can be drawn from a given research study. While there are numerous instruments available for assessing disordered eating, eating disorders (EDs), and associated psychopathology (Allison, 2009; Mitchell & Peterson, 2005), not all of these instruments are equally appropriate for assessment in a research context (Anderson & Murray, 2010). How then should researchers decide which measures to use in a research study? This chapter will provide some guidelines for those struggling with decisions about which measures to use in a research context. While we emphasize the use of assessment measures for treatment outcome research, the guidelines are applicable across research contexts.

Which Method of Assessment?

Researchers have many methods of assessment from which to choose, from interviews to self-report instruments to behavioral measures such as test meals. While it is beyond the reach of this chapter to discuss all aspects of choosing a method of assessment, we will review some issues particularly pertinent to the assessment of eating disorders.

Which Method of Assessment is Most Accurate?

It has been widely assumed that structured interviews represent the criterion method by which to assess ED symptomatology. In fact, one interview, the Eating Disorder Examination (EDE; Fairburn & Cooper, 1993; Fairburn, Cooper, & O'Connor, 2008), has been frequently described as the gold standard measure of ED symptomatology (Wade, Tiggemann, Martin, & Heath, 1997; Wilson, 1993; see also Chapter 38). While a number of studies have found discrepancies between rates of endorsement of ED-related constructs on interview versus questionnaire methods of assessment, it has generally been assumed that an interview allows for more detailed

The Wiley Handbook of Eating Disorders, First Edition. Edited by Linda Smolak and Michael P. Levine.

questioning and thus more accurate rates of responding (Anderson & Murray, 2010). However, a growing number of studies suggest that some individuals are embarrassed by and ashamed of their eating-disordered behavior and thus minimize their symptoms to a greater degree when having to discuss them face to face as opposed to a questionnaire (Anderson & Murray, 2010). Thus, it is not clear which method of assessment is most accurate. Until this issue is resolved, we recommend the use of both interview and self-report instruments.

Behavioral Measures of Eating Behavior

Denial and minimization are common problems in the assessment of ED symptomatology (Anderson, Lavender, & De Young, 2010). Moreover, humans are notoriously inaccurate at reporting food intake (Forrestal, 2011; Rutishauser, 2005; see also Chapter 24). Thus, it can be extremely useful to get an accurate assessment of eating behavior by directly observing eating using test meals or other similar approaches. Test meals allow for the assessment of multiple aspects of eating behavior and can be an excellent way to verify the validity of self-report assessment tools.

Guidelines have been developed for the use of test meals as an assessment measure (Anderson & Paulosky, 2004; Williamson, 1990), although, as will be discussed later in this chapter, they do not appear to have been widely adopted. Nevertheless, we recommend the use of behavioral measures of eating behavior such as test meals whenever feasible.

How Often to Assess?

The simplest strategy for assessing change is to assess participants before and after an intervention. This strategy has the advantages of being time- and cost-effective. However, it does not allow for a more detailed examination of the treatment process. Treatment outcome research, both within the ED field and without, is increasingly moving away from investigating simpler questions such as "Does this therapy work?" to investigating more complex questions of mediation, essentially "*How* does this therapy work?" (Kazdin, 2009; Kraemer, Stice, Kazdin, Offord, & Kupfer, 2001; Kraemer, Wilson, Fairburn, & Agras, 2002; Murphy, Cooper, Hollon, & Fairburn, 2009).

Answering such questions requires much more attention to the timing and frequency of assessments; in order to demonstrate mediation, change in the mediator needs to be shown to have occurred prior to change in the outcome of interest, and such changes often occur rapidly in the treatment process (Kazdin, 2009; Murphy et al., 2009). Thus, the best advice for assessment might be to assess early and often, perhaps even at every session.

How to Pick Specific Measures

Researchers can choose specific assessment measures for a multitude of reasons. In this section we will focus on two main justifications for choosing assessment measures and discuss the pros and cons of each.

Popularity

Sometimes researchers choose measures based on what others have used in previous studies or what measures are widely used in the literature. There are good reasons to do so; for example, using common measures allows for easy comparison across studies. This

practice can be problematic, however, when the commonly used measures do not accurately reflect the constructs of interest in a given research study. Also, the specific measures that are used commonly in the EDs literature have changed over time (aee Chapter 38).

Historical Patterns in the Use of Assessment Instruments for Treatment Outcome An early review of measures used in studies of bulimia nervosa (BN; Williamson, Anderson, & Gleaves, 1996) found considerable diversity in the type and number of measures used to evaluate treatment outcome. Most studies used multiple self-report questionnaires, and only one measure (the Eating Attitudes Test [EAT]; Garner & Garfinkel, 1979; Garner, Olmsted, Bohr, & Garfinkel, 1982) was used in 50% or more of the studies. Also, the EDE (Fairburn & Cooper, 1993; Fairburn et al., 2008) was used in fewer than 20% of studies.

A review in the mid-2000s (Anderson & Paulosky, 2004) found that patterns of assessment in treatment outcome research had changed somewhat. Although a large number of measures were still in use, three instruments had come to dominate the field. In studies of both anorexia nervosa (AN) and BN, two self-report measures were overwhelming favorites; the EAT and variations of the Eating Disorders Inventory (EDI; Garner, 1991; Garner, Olmstead, & Polivy, 1983). Use of the EDE remained steady. The majority (i.e., over 80%) of the reviewed studies of BN used self-report tools (often in the form of food records) to measure binging and purging.

These patterns have changed considerably in recent years. Tables 40.1–40.5 show the assessment measures used in recent treatment trials for EDs using cognitive-behavior therapy (CBT), family-based therapy (FBT), interpersonal therapy (IPT), dialectical behavior therapy (DBT), and mindfulness-based therapies (see Chapters 56, 57, 60, & 62). Table 40.6 provides more specific information about the various measures. As can be seen from these tables, while a wide variety of self-report measures are still being used, the questionnaire version of the EDE (EDE-Q; Fairburn & Beglin, 1994, 2008) has increased in popularity, particularly in trials of CBT. The EDE itself has also come to be used widely, again particularly among trials of CBT. This is in some ways not surprising, as the EDE and EDE-Q were designed by the primary developer of CBT-based treatments for EDs (Fairburn, 2008), and thus are a good theoretical match with CBT. As can be seen in the tables, however, it has also been used in studies of therapies other than CBT. Neither the EAT nor the EDI have been commonly used in more recent studies. Also in contrast to previous reviews, the use of self-monitoring as an assessment measure has decreased markedly. Conversely, the use of body mass index (BMI) as an outcome measure has increased markedly. This is to be expected; this review included trials of FBT for AN where previous reviews emphasized trials for BN, and more recent trials of CBT have included underweight individuals. In these cases change in BMI is a critical outcome measure. Finally, although they have been recommended (e.g., Anderson & Murray, 2010), behavioral measures of eating, such as test meals, remain rare.

As noted previously, the fact that a small number of assessment instruments have become popular in treatment outcome research (i.e., the EDE, EDE-Q, and BMI) is a positive development in that it allows for comparisons across studies. The EDE and EDE-Q also have very respectable psychometrics (Allison, 2009). Thus, although there have been some slight concerns about the EDE as an instrument (Anderson, De Young, & Walker, 2009), we encourage the use of these measures in research contexts whenever possible.

Table 40.1 Measures used in recent randomized controlled trials: cognitive-behavioral therapy for eating disorders.

	BASS[a]	*BIATQ*[b]	*BMI*[c]	*BSQ*[d]	*BAT*[e]	*BITE*[f]	*EAT-26*[g]	*EDE*[h]	*EDE-Q*[i]	*EDI*[j]	*Global AN*[k]	*Hunger Ratings (Visual Analogue Scale)*	*M-R*[l]	*SIAB-EX*[m]	*Self-monitoring*	*Test meal*	*SIBID*[n]	*TFEQ*[o]	*YBC-ED*[p]
Fairburn et al. (2009)			X					X	X										
Pike et al. (2003)			X										X						
McIntosh et al. (2005)			X					X		X	X								
Wilfley et al. (2002)			X					X											
Hilbert & Tuschen-Caffier (2004)				X				X								X			
Grilo et al. (2012)[1]			X						X						X			X	
Grilo et al. (2012)[2]			X					X											
Sanchez-Ortiz et al. (2011)								X											
Mitchell et al. (2011)			X					X											X
Byrne et al. (2011)			X					X	X	X									
Fairburn et al. (2013)			X					X	X										

Dalle Grave et al. (2013)			X					X						
Marco et al. (2013)	X	X		X	X	X							X	
Wagner et al. (2013)									X		X			
Munsch et al. (2012)			X						X					
Masheb et al. (2011)			X				X			X		X		X
Grilo & Masheb (2005)			X				X	X				X		X
Ruwaard et al. (2012)				X				X						
Wilson et al. (2010)							X							

Note. [a] Body Areas Satisfaction Scale, [b] Body Image Automatic Thoughts Questionnaire, [c] Body Mass Index, [d] Body Shapes Questionnaire, [e] Body Attitudes Test, [f] Bulimic Inventory Test, Edinburgh, [g] Eating Attitudes Test-26, [h] Eating Disorders Examination, [i] Eating Disorders Examination Questionnaire, [j] Eating Disorders Inventory-II, [k] Global Rating of Anorexia-Nervosa, [l] Morgan-Russell Outcome Criteria, [m] Structured Interview for BN/AN, [n] Situational Inventory of Body Image Dysmorphia, [o] Three Factor Eating Questionnaire, [p] Yale-Brown-Cornell Eating Disorders Scale.

[1] Grillo, White, Wilson, Gueorguieva, & Masheb (2012); [2] Grilo, Crosby, Wilson, & Masheb (2012).

Table 40.2 Measures used in recent randomized controlled trials: family-based therapy.

	BMI[a]	*ChEAT*[b]	*Course of ED*[c]	*DSM-IV*[d]	*EATATE*[e]	*EAT*[f]	*EDE-Q*[g]	*EDE*[h]	*EDI*[i]	*ICD-10*[j]	*M-R*[k]	*Relapse*[l]	*SEED*[m]	*YBC-ED*[n]
Dare et al. (2001)	X		X	X							X			
Eisler et al. (2000)	X		X			X			X	X	X	X		
Geist et al. (2000)	X								X					
LeGrange et al. (2007)	X						X	X						
Levine et al. (2001)	X	X												
Lock et al. (2005)	X		X	X				X						X
Lock et al. (2010)	X			X				X				X		X
Schmidt et al. (2007)	X				X								X	

Note. [a] Body Mass Index, [b] Children's Eating Attitudes Test, [c] Course of Disorder (i.e., duration previous treatment), [d] Criteria for ED—*Diagnostic and Statistical Manual for Mental Disorders* 4th ed., text revision, [e] EATATE semistructured interview (based on Longitudinal Interval Follow-Up Evaluation), [f] Eating Attitudes Test-40, [g] Eating Disorders Examination-Questionnaire, [h] Eating Disorders Examination, [i] Eating Disorders Inventory-II, [j] Criteria for ED—*International Classification of Diseases-10*, [k] Morgan-Russell Outcome Criteria, [l] Relapse/Remission Status, [m] Short Evaluation for Eating Disorders, [n] Yale-Brown-Cornell Eating Disorders Scale.

Table 40.3 Measures used in recent randomized controlled trials: interpersonal therapy.

	BMI[a]	*Course of ED*[b]	*EDE*[c]	*EDI-II*[d]	*Global Rating AN*[e]
Agras et al. (2000)			X		
McIntosh et al. (2005)	X	X	X	X	X
Wilfley et al. (2002)	X		X		
Wilson et al. (2010)			X		

Note. [a]Body Mass Index, [b]Course of Disorder (i.e. duration, length of treatment), [c]Eating Disorder Examination, [d]Eating Disorders Inventory-II, [e]Global Rating of Anorexia Nervosa.

Table 40.4 Measures used in recent randomized controlled trials: dialectical behavioral therapy.

	BES[a]	*BMI*[b]	*DEB-Q*[c]	*EDE*[d]	*EDE-Q*[e]	*EDI-II*[f]	*IA-E*[g]	*MAC-S*[h]	*PEWS*[i]	*QEWP*[j]	*Self-Monitoring*	*Test Meal*	*TFEQ*[k]
Chen et al. (2008)		X		X	X								
Hill et al. (2011)		X		X			X	X	X		X		
Kröger et al. (2010)		X				X					X	X	X
Robinson & Safer (2012)		X		X						X			
Roosen et al. (2012)		X	X			X							
Safer & Booil (2010)		X		X						X			
Safer & Joyce (2011)		X		X						X	X		X
Telch et al. (2001)	X	X		X									

Note. [a]Binge Eating Scale, [b]Body Mass Index, [c]Dutch Eating Behaviors Questionnaire, [d]Eating Disorders Examination, [e]Eating Disorders Examination-Questionnaire, [f]Eating Disorders Inventory-II, [g]Interoceptive Awareness Scale-Expanded, [h]Mizes Anorectic Cognitions Scale, [i]Preoccupation with Eating, Weight, and Shape Scale, [j]Questionnaire on Weight and Eating Patterns, [k]Three Factor Eating Questionnaire.

Table 40.5 Measures used in recent randomized control trials: mindfulness-based therapies.

	BES[a]	*Bio markers*[b]	*BMI*[c]	*BSQ*[d]	*DEB-Q*[e]	*Diet adhere*[f]	*EAT-26*[g]	*EDE-Q*[h]	*EDI-II*[i]	*FAAQ*[j]	*G-FCQ-T*[k]	*MAC-S*[l]	*PASTAS*[m]	*PEWS*[n]	*Self-monitoring*	*TFEQ*[o]
Alberts et al. (2012)			X	X	X						X					
Daubenmier et al. (2011)		X	X		X											
de Zwaan et al. (2009)			X		X			X							X	
Forman et al. (2009)			X		X					X					X	X
Pearson et al. (2012)			X				X		X			X	X	X	X	
Rain Carei et al. (2010)			X													
Tapper et al. (2009)	X		X		X	X										

Note. [a] Binge Eating Scale, [b] biomarkers (described in Methods), [c] Body Mass Index, [d] Body Shapes Questionnaire, [e] Dutch Eating Behaviors Questionnaire, [f] adherence to prescribed diet, [g] Eating Attitudes Questionnaire-26, [h] Eating Disorders Examination-Questionnaire, [i] Eating Disorders Inventory-II, [j] Food Related Acceptance and Action Questionnaire, [k] General Food Craving Questionnaire, [l] Mizes Anorectic Cognitions Scale, [m] Physical Appearance State and Trait Anxiety Inventory-Stats Version, [n] Preoccupation with Eating Weight and Shape Scale, [o] Three Factor Eating Questionnaire.

Table 40.6 Summary of recommended measures.

Measure	*Constructs assessed*	*Notes*
1. Body Areas Satisfaction Scale (BASS)	Body satisfaction/ dissatisfaction	Developed by Cash (2002); subscale of the Multidimensional Body Self-Relations Questionnaire
2. Body Image Automatic Thoughts Questionnaire (BIATQ)	Cognitive distortions related to appearance	Developed by Brown et al. (1990)
3. Body Shapes Questionnaire (BSQ)	Body satisfaction/ dissatisfaction	Developed by Cooper et al. (1986)
4. Body Attitudes Test (BAT)	Body satisfaction/ dissatisfaction	Developed by Probst et al. (1995); four subscales: negative appreciation of body size: lack of familiarity with one's own body: general body dissatisfaction: and a rest factor
5. Binge Eating Scale (BES)	Presence of binge eating behaviors, cognitions, and emotions typical of those who binge eat	Developed by Gormally et al. (1982); provides cut-offs for nonbingeing, moderate, and severe bingeing behavior
6. Bulimic Investigatory Test, Edinburgh (BITE)	Bulimic behaviors	Developed by Henderson & Freeman (1987); includes symptom and severity subscales; has only been validated in adult women and adolescents of both sexes
7. Children's Eating Attitudes Test (ChEAT)	Symptoms and concerns characteristic of eating disorders	Developed by Maloney et al. (1988); adapted version of the EAT-26 for children 8–13; may need additional adaptations for younger children (Smolak & Levine, 1994)
8. Dutch Eating Behaviors Questionnaire (DEB-Q)	General structure of eating behaviors	Developed by van Strien et al. (1986); Scales for emotional, external, and restrained eating
9. EATATE semistructured interview	Weight and ED history	Semistructured interview (Schmidt et al., 2007) based on the Longitudinal Interval Follow-up Evaluation (Keller et al., 1987); validation of the measure not yet published
10. Eating Attitudes Test-26/40 (EAT-26/ EAT-40)	Symptoms and concerns characteristic of eating disorders	Developed by Garner & Garfinkle (1979); cannot be used to make a diagnosis

(*Continued*)

Table 40.6 (*Continued*)

Measure	*Constructs assessed*	*Notes*
11. Eating Disorders Examination (EDE)	Behavior and attitudinal symptoms of disordered eating	Developed by Fairburn, Cooper, & O'Connor (2008)
12. Eating Disorders Examination-Questionnaire (EDE-Q)	Behavior and attitudinal symptoms of disordered eating	Developed by Fairburn & Beglin (2008)
13. Eating Disorders Inventory-II (EDI-II)	Behaviors and psychological features associated with ED	Developed by Garner (1991)
14. Food-related Acceptance & Action Questionnaire (FAAQ)	Psychological flexibility in a food-rich environment	Developed by Juarascio et al. (2011); subscales assessing acceptance of distressing food-related thoughts/cravings and willingness to engage in healthy eating despite these experiences; measure has only been validated in undergraduate/community samples
15. General Food Craving Questionnaire	Possible precipitants and consequences of general food cravings	Developed by Nijs, Franken, & Muris (2007); an adapted version of the Trait and State Food Cravings Questionnaire (Cepeda-Benito, Gleaves, Williams, & Erath, 2001)
16. Interoceptive Awareness Scale-Expanded (IAS-E)	Awareness of appetite signals and emotions	Developed by Craighead & Niemeier (2002); expanded version of the Interoceptive Awareness Scale of EDI-2 in order to include appetite awareness and emotional awareness
17. Mizes' Anorectic Cognitions Scale	Typical cognitions relevant to AN/BN	Developed by Mizes & Klesges (1989). Revised versions available (Mizes, 1994; Mizes et al., 2000)
18. Morgan Russell Outcome Criteria (M-R)	Recovery status in those with AN	Developed by Morgan & Hayward (1988); general criteria only speak to weight recovery and menstrual status and dichotomizes success into "good/intermediate/bad"
19. Physical Appearance State and Trait Anxiety Inventory-State Version (PASTA)	Current anxiety/nervousness about 16 specific body parts	Developed by Reed et al. (1991)
20. Preoccupation with Eating Weight and Shape Scale (PEWS)	Frequency and distress related to eating and weight/shape-related thoughts	Developed by Niemeier et al. (2002)

Table 40.6 (*Continued*)

Measure	*Constructs assessed*	*Notes*
21. Questionnaire on Weight and Eating Patterns (QWEP)	Assessment of eating patterns characteristic of BED	Developed by Spitzer et al. (1992); can classify individuals into no diagnosis, nonclinical levels of bingeing, and BED; adolescent and parent completion forms available
22. The Structured Interview for Anorexic and Bulimic Disorders for DSM-IV and ICD-10	Assessment and diagnostic categorization of ED	Newest version developed by Fichter & Quadflieg (2001); semistructured interview that shows correlations with the EDE
23. Situational Inventory of Body Image Dysmorphia	Frequency and intensity of negative appearance-related feelings in various situational contexts	Developed by Cash (1994); useful for determining situations that are distressing for persons with body-image difficulties
24. Short Evaluation for Eating Disorders	Key ED symptoms (3 for AN, 3 for BN)	Developed by Bauer, Winn, Schmidt, & Kordy (2005); allows user to calculate severity index for AN/BN
25. Three Factor Eating Questionnaire (TFEQ)	Three dimensions of human eating behavior—cognitive restraint, disinhibition, hunger	Developed by Stunkard & Messick (1985)
26. Yale-Brown Eating Disorders Scale (YB-ED)	Severity of illness in those with EDs	Developed by Sunday et al. (1995). Subscales that assess rituals/preoccupations and motivation for change

Patient Characteristics

Specific patient characteristics can be important when selecting assessment measures. On one hand, measures are often developed for or with specific populations (e.g., gender, diagnosis) and difficulties can arise when using measures on populations for which they were not designed (see Chapters 23 & 37). For example, many body image assessment instruments were developed on female samples and assess stereotypically female body image concerns (e.g., large hips and thighs), and some have argued that they may be inappropriate for use in males (Darcy & Lin, 2012; Thompson & Cafri, 2007). Also, with the advent of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013), some older measures may not reflect current diagnostic criteria. Broadly speaking, researchers should select measures developed on their population of interest and for which there are appropriate norms.

On the other hand, researchers may have theoretical or practical reasons for wanting to use a specific measure, or a measure may not be available for their population of interest. Thankfully, norms have been developed for some measures for different populations than those for which

the measure was originally designed (see Allison, 2009, for extensive norms for eating disorders measures). It should be noted, however, that whenever a measure is used in a sample substantially different from the group on which it was developed, there exists a risk that the measure in question will exhibit differential item functioning (DIF), or item bias. DIF occurs when specific items within a measure exhibit different probabilities of item endorsement relative to group membership. This means that a member of one group would have a decreased probability of endorsing an item relative to a member of another group when the overall score on the measure is held constant. If DIF is present within a measure, one can assume reduced variability and subsequently misleading results regarding the latent trait. While very few eating-related measures have been subjected to DIF analysis, those that have been conducted have found substantial gender-specific item bias in measures of body checking (Alfano, Hildebrandt, Bannon, Walker, & Walton, 2011). Thus, even though norms may be available for a measure, a given score may not accurately reflect the underlying construct of interest. Until this issue is investigated more thoroughly in the EDs literature, researchers should interpret with some caution scores on measures developed under different populations than those they are studying.

Theory Testing

It has been argued that the theoretical model underlying treatment should play a critical role in the choice of assessment instruments (Anderson & Murray, 2010). CBT, DBT, FBT, and IPT all have some evidence for their efficacy in treating EDs (Hay, 2013; see also Chapters 56, 57, 60, & 62), but all are thought to achieve their effects through different mechanisms (Arcelus, Haslam, Farrow, & Meyer, 2013; Fairburn, Cooper, & Shafran, 2003; Lock, Le Grange, Agras, & Dare, 2001; MacPherson, Cheavens, & Fristad, 2013; Murphy et al., 2009; Murphy, Straebler, Basden, Cooper, & Fairburn, 2012). To test the possible mechanisms of these treatments, it is necessary to choose assessment instruments that measure the critical constructs and mechanisms of interest. As an example, CBT postulates that the core psychopathology of most eating disorders is the overvaluation of shape and weight and their control (Fairburn, 2008; see also Chapter 56). Accordingly, studies of CBT for EDs should include an assessment of this construct. DBT, however, suggests that failures in emotion regulation are a key feature in the maintenance of EDs (MacPherson et al., 2013; see also Chapter 57) and, as such, studies of DBT for EDs should assess emotion regulation where studies of CBT might not.

Historically, however, the EDs field has not done well in this regard. For example, an earlier review of CBT for BN found that researchers focused on the overt behavioral symptoms of BN more than the cognitive and other symptoms of the disorders, and almost no studies assessed all of the core domains hypothesized to play a role in the maintenance of the disorder (Anderson & Maloney, 2001). More recently, a review of DBT for EDs found that no studies to date have directly assessed a key component of the DBT model—that DBT improves emotion regulation skills and abilities (Bankoff, Karpel, Forbes, & Pantalone, 2012). Moreover, the IPT model for the development and maintenance of eating disorders (see Chapter 62) has not yet been directly tested (Murphy et al., 2012).

However, things are improving somewhat. As noted previously, researchers in the EDs field have begun to call for increased investigation of underlying mechanisms of change by investigating mediators of treatment (Kraemer et al., 2001, 2002; Murphy et al., 2009). This process requires careful thought about the instrument or instruments used to assess the proposed underlying mechanism as well as the timing of administration (Kazdin, 2009; Murphy et al., 2009). Researchers interested in investigating CBT have the advantage of having measures available that

specifically assess the underlying model of the treatment (i.e., the EDE and EDE-Q). Unfortunately, there are few options for researchers wishing to test other models of EDs.

Conclusions and Future Directions

The assessment of EDs and related symptoms has evolved over the past decades. To help advance the field, we offer the following suggestions:

1 Make sure to match assessment instruments to the underlying theory being tested. This will allow for better testing of these theories, as well as possible mediators of change.
2 Assess as often as is feasible. Because change often happens early in treatment, frequent assessment is necessary to capture this process.
3 Use popular measures, but not only popular measures. It is extremely helpful to be able to compare results across studies, and a common metric facilitates this process. But supplementary measures may be necessary to assess all aspects of the underlying theory. New measures may need to be developed to assist in this process.

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