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Development and validity of a very short form of the Eating Disorder Inventory

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Abstract

Introduction: The main objective of the present series of studies was to develop and validate a 16-item very short form of the Eating Disorder Inventory (EDI-VS) for use as a short assessment tool in large-scale comprehensive or longitudinal studies, as well as in-depth idiographic studies.
Method: The EDI-VS was developed, and validated, through a series of five studies based on independent community samples including a total of 1372 French adolescents.
Results: The results supported the reliability, content validity, factor validity, convergent validity, and criterion-related validity of the EDI-VS.
Conclusions: The EDI-VS comprises 16 items assessing the eight original dimensions of the conceptual model for the EDI. Recommendations for future practice and research on the EDI-VS are outlined.
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1. Introduction

Eating disorders (ED) are pervasive developmental disorders characterized by problematic self-images and eating attitudes and behaviors [1]. They are known to be associated with a wide array of severe negative consequences, with death as a possible outcome [2]. Prevalence rates of ED remain low (≤1%) among young females [3]. However, subclinical Disturbed Eating Attitudes and Behaviors (DEAB) are far more prevalent [4,5] and represent significant predictors of clinical levels of ED [1].

Numerous self-report questionnaires have been developed to assess DEAB in the general population [6–10]. These instruments generally focus on DEAB related to specific types of ED [11–15] or on most of the core components of ED [16–20]. Most of these instruments have been validated or adapted for adolescents. However, their length (22–64 items) is a serious drawback for large-scale comprehensive studies and in-depth idiographic studies, where it may create an unnecessary burden and undermine compliance with, and participation in, the study. Unfortunately, very few short instruments are available to assess DEAB in the general population [10,21]: The eight-item Eating Disorder Examination-Screening Version [22], the five-item Eating Disturbance Scale [23], the eight-item Risk Behavior for Eating Disorders [24], the five-item SCOFF [25], the six-item Short Evaluation of Eating Disorders [26], and the five-item screening version of the Eating Disorder Inventory (EDI; [21]). However, these screening instruments tend to focus on a limited number of ED/DEAB characteristics and to sacrifice precision through the reporting of a single global score, rather than providing comprehensive multidimensional assessments. These instruments also generally rely on Likert-type response scales, which tend to be associated with insufficient variability at

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the item-level to provide precise repeated assessments providing sufficient sensitivity to short-term fluctuations [27,28].

Given the absence of short multidimensional measures of DEAB suitable for intensive idiographic studies, the development of such instruments has been identified as a research priority [29,30]. The purpose this article was to develop and validate a very short form (2-item per scale) of the EDI [18], the EDI-VS, following guidelines for short-form development [31–35]. The EDI was retained for two reasons. First, most instruments are limited to a specific form of ED (AN, BN) and assess a restricted range of DEAB characteristics, whereas the EDI evaluates the full range of DEAB (Body Dissatisfaction, Bulimia, and Drive for Thinness), as well as personality characteristics associated with ED (Ineffectiveness, Perfectionism, Maturity Fears, Interpersonal Distrust, and Interoceptive Awareness). Second, the EDI is the most widely used [36,37] and cross-validated [38–40] instrument for the assessment of DEAB. In this adaptation, Likert scales were replaced with visual analog scales (VASs; where respondents mark their answers on a continuous line [27,28]) that: (a) have more discriminating capacity and variability than alternative formats; (b) do not impose artificial categories on responses; (c) are less vulnerable to memory effects and consistency biases; (d) are suitable for frequent and repeated use; and (e) have an established reliability and validity.

This series of five studies is based on five independent samples and met the ethical requirements for research with human participants in France. Appropriate consent procedures were followed to obtain participants' voluntary agreement prior to data collection. The *first study* aimed to develop a preliminary version of the EDI-VS using a VAS answer scale. The *second study* verified the first-order and higher-order factor structure of the EDI-VS, its reliability, and its invariance across genders [41] given that DEAB are known to take different forms and to emerge from different risk factors in boys and girls [42]. The *third study* verified the relations between the global and scale scores of the EDI-VS and those from the original EDI [31]. It was hypothesized that the EDI-VS scales would be more strongly related to corresponding EDI scales than to other EDI scales. The *fourth study* verified the convergent validity of the EDI-VS with another measure of DEAB (Eating Attitudes Test; EAT-26 [11,43,44]), as well as with measures representing central components of ED [1,45–47]: global self-esteem and social physique anxiety. Previous research revealed (a) positive correlations between scores on the EAT-26 and the global , drive for thinness, bulimia, body dissatisfaction, and interoceptive awareness scales of the EDI [18,48]; (b) positive associations between scores on social physique anxiety and the drive for thinness, bulimia, and body dissatisfaction scales of DEAB instruments [49,50]; and (c) negative relations between scores on global self-esteem and the body dissatisfaction, ineffectiveness, perfectionism and interpersonal distrust scales of DEAB measures [18,51,52]. The same pattern of correlations was expected here. The *fifth study* tested the criterion-related validity of the EDI-VS in participants with AN and without ED to see whether the EDI-VS could also be used for screening purposes. As already found in previous studies [36,39,40] it is expected that clinical participants with ED scored significantly higher than community controls on all scales of the EDI.

2. Methods

2.1. Participants and Procedures

Study 1. A sample of 291 adolescents [M_{age} = 14.32; mean body mass index (BMI; weight/height*height) = 19.37, SD_{BMI} = 1.19], including 156 boys and 135 girls, was recruited in three French secondary schools. All Participants completed French version of the EDI [38].

Study 2. A sample of 900 adolescents (M_{age} = 13.70; M_{BMI} = 19.21, SD_{BMI} = 2.59), including 450 boys (M_{age} = 13.71 years; M_{BMI} = 19.53) and 450 girls (M_{age} = 13.70 years; M_{BMI} = 18.88), was recruited in four French secondary schools. All participants completed the EDI-VS developed in Study 1.

Study 3. A sample of 51 adolescents (M_{age} = 13.94; M_{BMI} = 19.67, SD_{BMI} = 2.84), including 26 boys and 25 girls, was recruited in two French secondary schools. The participants completed the French versions of the EDI [38] and EDI-VS, in a randomly assigned order.

Study 4. A sample of 92 adolescents (M_{age} = 14.59; M_{BMI} = 19.47, SD_{BMI} = 0.85), including 35 boys and 57 girls, was recruited in two French secondary schools. The participants completed the EDI-VS and the French version of the EAT-26 [53,54], the Rosenberg Self-Esteem Inventory (RSEI; [55,56]), and the Social Physique Anxiety Scale (SPAS; [47,57]).

Study 5. A sample of 38 adolescent girls (M_{age} = 15.68; M_{BMI} = 17.21, SD_{BMI} = 2.02), including 19 without ED and 19 suffering from anorexia nervosa was involved in this study and completed the EDI-VS. Anorexic patients were recruited in a psychiatric unit where 74% received inpatient treatment. Girls without ED were recruited in a French secondary school and were screened negative for history of ED with the fifth French version of the Mini International Neuropsychiatric Interview (MINI; [58]).

2.2. Measures

2.2.1. EDI

The 64-item French version of the EDI [38] assesses: (a) DEAB (Body Dissatisfaction; Bulimia; and Drive for Thinness); and (b) personality characteristics commonly related to ED (Ineffectiveness; Perfectionism; Interpersonal Distrust; Interoceptive Awareness; and Maturity Fears). Each item is rated on a six-point scale (always to never).

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