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Development and preliminary validation of the Testable Assumptions Questionnaire—Eating Disorders (TAQ-ED)

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Abstract

Background: While cognitive formulations of eating disorders emphasise the role of dysfunctional assumptions regarding eating, weight and shape (EWS), less is known about the role of dysfunctional assumptions that are unrelated to EWS and those linking beliefs about EWS with negative beliefs about the self or the world. The present study aimed to develop a brief measure of dysfunctional assumptions in the eating disorders and to validate it clinically. Given that cognitive-behavioural therapy frequently involves the testing of patients' assumptions with the help of behavioural experiments, the measure was designed specifically to assess assumptions that can be addressed using such techniques.
Method: The sample consisted of 79 women with DSM-IV eating disorder diagnoses. Each participant completed the measure of testable assumptions in the eating disorders (TAQ-ED), the Eating Disorders Inventory (EDI) and the Brief Fear of Negative Evaluation scale (Brief FNE).
Results: The TAQ-ED was made up of three scales, each of which had acceptable psychometric properties. High scores on the eating attitudes/behaviours scales of the EDI and on the Brief FNE were broadly associated with dysfunctional assumptions about the world and one's body. In contrast, high scores on ego-dysfunction scales of the EDI were associated with dysfunctional assumptions about feelings.
Conclusions: Different aspects of eating disorder pathology appear to be linked to different types of dysfunctional assumptions in the eating disorders. The clinical value of the proposed new measure of dysfunctional assumptions is discussed, and ideas are provided for behavioural experiments testing such assumptions.

Keywords: Assumptions; Cognition; Behavioural experiments; Anorexia; Bulimia; Eating disorders

Existing cognitive-behavioural formulations of the eating disorders treat dysfunctional assumptions about eating, weight and shape as central to the maintenance of these problems (Fairburn, Cooper, & Shafran, 2003; Vitousek, 1996). Such assumptions (also referred to as 'conditional beliefs,' 'attitudes' or 'rules') are intermediate beliefs that can often be stated as "If. . .then. . ." or "should" statements (e.g., "If I feel big, it means I have put on weight"; "Most people would notice if I put on two pounds").

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While assumptions about eating, weight and shape are clearly of relevance to eating psychopathology, clinical observation suggests that assumptions that are not related to eating, weight and shape are also important. For example, eating-disordered patients frequently report assumptions about the perceived consequences of expressing negative feelings (e.g., "If I tell others how I feel inside, they will reject me"), or ones that link beliefs about eating, shape and weight with negative beliefs about the themselves or other people (e.g., "Being overweight means you have failed as a person"; "If I were overweight, most people would ridicule or humiliate me"). Many of the latter assumptions are concerned with others' anticipated reactions to changes in the patient's weight or shape, suggesting that social anxiety may play a role here. Such a link would be consistent with research showing social anxiety to be a significant problem in patients with eating disorders (e.g., Gilbert & Meyer, 2005; Hinrichsen, Wright, Waller, & Meyer, 2003).

While existing self-report measures of cognition in the eating disorders have typically focused on the assessment of negative thoughts and assumptions regarding eating, weight and shape (in line with theoretical accounts) (e.g., Fairburn & Beglin, 1994), more recent measures have identified additional assumptions and core beliefs that might be relevant in this population (e.g., Cooper, Cohen-Tovee, Todd, Wells, & Tovee, 1997; Cooper, Todd, & Wells, 1998; Waller, Ohanian, Meyer & Osman, 2000). For example, the Eating Disorder Beliefs Questionnaire (EDBQ: Cooper et al., 1997) identifies (among other cognitions) a number of eating, weight and shape-related assumptions (e.g., "If I eat forbidden food, I won't be able to stop"; "If I eat desserts and puddings I'll get fat"), as well as assumptions linking eating, weight and shape concerns with beliefs about the world (e.g., "If I lose weight, I'll count more in the world"; "If my hips are thin, people will approve of me"). While the EDBQ is the currently most comprehensive measure for the assessment of the range of cognitions in the eating disorders, it has two shortcomings: first, it does not identify dysfunctional assumptions about feelings; second, no links are made between specific assumptions and aspects of the patients' psychopathology (e.g., use of bulimic or restrictive behaviours, social anxiety).

The identification of dysfunctional assumptions is critical in the planning of cognitive-behavioural treatment, as therapy often involves the testing of such assumptions with the help of behavioural experiments. Despite the widely recognised importance of behavioural experiments as the most powerful clinical tools to alter dysfunctional assumptions (Bennett-Levy et al., 2004; Cooper, Whitehead, & Boughton, 2004), none of the self-report measures currently available focus specifically on the identification of assumptions that can be tested with the help of behavioural experiments. A measure of dysfunctional assumptions that are testable with the help of such experiments could be useful for cognitive-behavioural therapists looking to identify specific targets for treatment.

Therefore, the first aim of the present study was to develop and provide preliminary validation for a self-report measure of testable dysfunctional assumptions that are commonly reported by patients with eating disorders. The second aim of this study was to explore how these different types of assumptions might be related to patients' eating psychopathology and to other common comorbid problems, such as social anxiety.

1. Method

1.1. Participants

The participants were 79 women who had been referred to an eating disorders service, and who met DSM-IV criteria (American Psychiatric Association, 1994) for a diagnosis of anorexia nervosa ($N=17$), bulimia nervosa ($N=34$) or Eating Disorder Not Otherwise Specified (EDNOS; $N=28$). All patients were diagnosed at assessment by an experienced clinician, using a semi-structured interview (Waller, in preparation). Patients also had their height and weight assessed in order to calculate their body mass index (BMI = weight [kg]/height $[m]^2$). The participants had a mean age of 28.59 years (SD = 8.31, range 17–58), and their mean body mass index (BMI) was 22.52 (SD = 8.35, range 13–55).

1.2. Measures and procedure

Each participant completed three measures as part of a wider set of self-report scales. In addition, clinical measures were taken of frequencies of bingeing and vomiting, and laxative use.