SIAB
Professional Manual

Structured Inventory for Anorexic and Bulimic Eating Disorders (SIAB)

Questionnaire (SIAB-S) and Expert-rating (SIAB-EX)
according to DSM-IV and ICD-10

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Overview of the Structured Inventory for Anorexic and Bulimic Eating Disorders (SIAB). Questionnaire (SIAB-S) and Expert-rating (SIAB-EX) according to DSM-IV and ICD-10.

Title:

Structured Inventory for Anorexic and Bulimic Eating Disorders (SIAB). Questionnaire (SIAB-S) and Expert-rating (SIAB-EX) according to DSM-IV and ICD-10.

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Publisher:

Year of publication:

1999

Content:

The SIAB expert and self-rating each comprise 87 items covering eating disorder symptoms and other disorders (depression, anxiety), social integration, sexuality, exclusionary disorders and medication. Questions covering areas necessary for eating disorder diagnoses are included. The following diagnoses can be made by the SIAB-EX or the SIAB-S:

- Anorexia Nervosa according to DSM-IV,
  differentiating restricting and binge eating/purging type
- Bulimia Nervosa according to DSM-IV,
  differentiating purging and non-purging type
- Eating Disorder not otherwise specified according to DSM-IV including Binge Eating Disorder following the criteria in the appendix of the DSM-IV
- Anorexia Nervosa according to ICD-10
- Atypical Anorexia Nervosa according to ICD-10
- Bulimia Nervosa according to ICD-10
- Several additional eating disorder syndromes

Materials:

Manual with definitions, operationalizations and case examples for each item of the SIAB-EX, SIAB-EX interview, SIAB-S questionnaire, checklists for the sum scores and diagnoses, and computer algorithms for sum scores and diagnoses.

Probands:

Adolescents and adults aged 12 to 65 years

Subscales:

Six subscales and a total score each for past- and present (last 3 months) state for the SIAB-EX expert interview, and six (present state) resp. Seven (past) subscales and a total scale (separately for present and past) for the SIAB-S questionnaire. The subscales cover eating disorder symptoms (binges, weight phobia etc.) an general psychopathology (depression, anxiety, obsessive-compulsive symptoms), as well as social integration and sexuality.

Application:

Interview in individual settings face to face by trained expert raters (SIAB-EX).). Application by telephone is possible. Answering tthe questionnaire in an undisturbed atmosphere (SIAB-S

Time required:

Interview SIAB-EX 30 – 60 minutes, questionnaire SIAB-S about 30 minutes.

Data analyis:

Scoring of the subscales and computation of eating disorder diagnoses follows fixed instructions. Computer algorithms and form sheets are available.

Norms:

Comparison values of 377 males and females which were treated as in-patients because of their eating disorder as well as data on healthy women are available. Data on diagnostic subgroups Anorexia Nervosa and Bulimia Nervosa according to DSM-IV are also given.

Objectivity:

Objectivity regarding data collection, data analyis, and interpretation of the results is given.

Validity:

Data on convergent und discriminative construct validity are presented.

Reliability:

Data on inter-rater reliability (SIAB-EX), internal consistency, and agreement of SIAB-EX and SIAB-S are available.

1. Introduction

While anorexia nervosa is known for many years bulimia nervosa was described only recently in the clinical literature (Russell, 1979). In the mean time anorexia nervosa and bulimia nervosa are well established. Both clinical eating disorders are defined by operationalized criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA, 1994) as well as in the International Classification of Diseases (ICD-10; WHO, 1992). For each disorder inclusion and exclusion criteria are defined, as well as criteria covering duration and/or frequency of symptoms and course of the disorder. In the DSM-IV anorexia nervosa (307.10), bulimia nervosa (307.51) and several types of eating disorders not otherwise specified (307.50) are defined. For binge eating disorder (307.50) provisional criteria are given in the appendix. ICD-10 defines anorexia nervosa (F50.0, F50.1) and bulimia nervosa (F50.2).

In psychiatry, significant progress has been made in the past decade concerning the methodology of reliable and valid assessment and diagnostic classification. (Semi-)structured interviews have been developed for the assessment of general psychopathology such as the Present State Examination (PSE) by Wing, Cooper, & Sartorius (1974 a, b), The Diagnostic Interview Schedule by Robins et al. (1981, 1982) and the Structured Clinical Interview for DSM III-R Diagnosis (SCID) by Spitzer et al. (1987). Using standard probes and a manual with definitions and case examples and requiring interviewer training, interviews of this kind help to increase the reliability for symptom identification and for diagnosis.

Biological, psychological and psychiatric/medical research on eating disorders requires reliable and valid assessment of eating disorder symptoms. Bruch (1973), Russell (1979), Crisp (1980), Fairburn, Steere and Cooper (1990) and other experts describe symptoms in eating disordered persons which range from highly eating disorder specific problems (e. g. reduction of food intake, eating binges or self-induced vomiting) to symptoms which are frequently observed in eating disordered persons but which are shared with many mental disorders (e. g. depressive thoughts, problematic self—evaluation or social competence).

The SIAB-EX update takes into consideration other extant interviews covering eating disorders, e. g. the Eating Disorder Examination (EDE) by Cooper et al. (1989) and Clinical Eating Disorder Instrument (CEDRI) by Palmer et al. (1987). The CEDRI was not adapted to newer diagnostic developments and there are no data on its validity. The SIAB-EX has several positive characteristics: (1) It covers a wide range of eating disorder related psychopathology; (2) symptoms are assessed for current and past as well as ever in lifetime; (3) reliability and validity are checked; (4) clinical assessments as well as factor analytic methods were applied, resulting in the identification of important areas of psychopathology; (5) besides quantitative information on the psychopathology a solid data base for diagnostic classification according to DSM-IV and ICD-10 is provided (6) there exists a computer algorithm for diagnostic classification of anorexia nervosa (restrictive type, binge eating/purging type), bulimia nervosa (purging and non-purging type), and eating disorders not otherwise specified including binge eating disorder; (7) besides the SIAB-EX expert rating a parallel self-rating version (SIAB-S) was developed. The availability of both a self-rating and an expert-rating version of the same item offers some advantages. Values can be used for comparing self- and expert-rating. Self-rating methods can be used more economically. Therefore they are suited to be used in two- or more stage designs as screening instruments to identify high-risk persons. The SIAB may be used in clinical research and practice for quantitative evaluation and diagnostic classification. The interview provides a detailed description of clinical subgroups. It is suited to compare different diagnostic groups

(anorexia nervosa, bulimia nervosa, binge eating disorder, eating disorder not otherwise specified) with each other and with persons without eating disorder who show high concern regarding figure and weight. The SIAB may be used in longitudinal studies as well as for the evaluation of the impact of psychological or pharmacological treatment on the course and outcome of eating disorders. In longitudinal studies the empirically derived subscales of the SIAB are suitable predictors of course and outcome.

The SIAB-EX is the only expert interview covering eating disorders which has a comprehensive manual. This is very important for training of interviewers and to secure high interrater reliability. The manual includes an extensive chapter which gives typical case examples for clinical and scientific practice. The manual is indispensible for the use of the SIAB-EX. Only if the manual is used reliable and valid results can be expected.

2. SIAB-EX expert interview

2.1 General description of the SIAB-EX

The third revision of the SIAB-EX comprises 87 items. Some items are broken down in several partial items. For the diagnostic classification according to DSM-IV and ICD-10 the SIAB was supplemented with some items referring to specific aspects newly introduced by these recent diagnostic systems. Some items concerning clinical aspects of eating disorders recently brought to attention were added. E. g. disorders which show a high comorbidity with obesity such as binge eating disorder find increased interest with clinical psychologists and psychiatrists.

For most items the results are coded on a five-point scale ranging from 0 (symptom/problem not present) to 4 (symptom/problem very severely present). Generally the scale is defined as follows:

0 = symptom/problem area not present
1 = symptom/problem area slightly or rarely present
2 = symptom/problem area markedly or sometimes present
3 = symptom/problem area severely or frequently present
4 = symptom/problem area very severely or very frequently present

There are additional questions necessary for the diagnostic classification according to DSM-IV or ICD-10. The content of items refers to all areas relevant to eating disorders as well as other symptoms of disturbed behavior (depression, anxiety).
For most items the cross-sectional status (was the symptom present in the last 3 months) and the maximal expression of the symptom in the past is rated by the expert interviewer. The past rating will usually cover the time from prepuberty up to 3 months before the interview. The present status covers the maximal expression of the symptom/problem area in the last 3 months before the interview if not specified otherwise.

Principal component analysis with varimax-rotation showed that the best solution comprised 6 factors for the present state and for the past. See tables 16 and 17 below for the factor structure. The six factors after rotation explained 42.8% (past) and 40.5% (present state) of the variance. Details on the construction of the scales can be found in Fichter, Elton, Engel, Meyer, Mall & Poustka (1991) and Fichter, Herpertz, Quadflieg & Herpertz-Dahlmann (1998).[1]

2.2 Content and application of the SIAB-EX

The SIAB may be used with all persons who are supposed be have an eating disorder. It may also be used in epidemiologic studies. For epidemiologic studies the use of the SIAB self-rating version is highly recommended as a screening for the identification of high risk persons.
The interview should take place in an undisturbed setting. It is highly important to establish a good working relation with the proband. Sufficient time for the exploration of each item should be allowed.
The SIAB-EX interview is conducted by clinical experts which have to be trained skillfully. Ratings are to be done for the present state as well as for the past time since puberty up to 3 months before the interview. An item which is not applicable for a certain proband (e. g. menstruation if the proband is male) should be coded as 8, refused answers and items not explored should be coded as 9 (missing value). Generally each item is explored first for the present state (last three months) and then for the worst in the past (excluding the last three months).
The retrospective assessment of symptoms and problems areas requires careful and skilled exploration on the side of the interviewer. The interviewer has to ask explicitly in each probe what the maximal expression of the symptom or problem area was in the past and at present (last 3 months). Notice that both ratings (past and presence) ask for the maximal symptom expression and not the average! An item usually consists of the obligatory main probe (e.g. „Have you dieted or restricted food intake in the past three months or in former years?“). If the symptom or problem is not and has not been present at all, go on to the next question; if there are any indications that the symptom or problem may have been or is present, use the additional probes and if necessary, explore further in order to be able to make a judgement (e.g. „Did you count calories? Did you try to eat as little as possible or less than your body would have needed to keep a stable weight? Did you diet or fast during the day as long as possible or to eat only in the evening?"). It is the objective to condense the information obtained in the interview. For that reason the interviewer has to combine complex pieces of information into one rating. For example in the question concerning laxative abuse the interviewer has to take into account possible denial on the side of the patient, the frequency of laxative abuse, the kind of laxative used, and the dosage before making a rating on "laxative use". The interviewer should take into account all information he or she obtained during the interview including gestures, facial expression, intonation and what is said between the lines. Some eating disordered patients tend to deny very much while others may exaggerate. The SIAB-EX is not a self-rating scale but rather an expert-rating scale. The expert interviewer should therefore filter the information he or she obtains from the patient and rate it on objective grounds based on the definitions descriptions and operationalizations described in the next section. Each item should be rated globally and coded in the code column on the right side of the interview.
The rating of the symptoms should be descriptive and not judgmental. If for example the patient shows depressive mood and depressive thoughts, the severity of the depressive symptom should be coded independently of the opinions about the origin of the depressive symptoms (reactive depression, endogenous depression). Only if the interviewer has reason to believe that the patient is not telling the truth (exaggerating or denying a symptom for which there is evidence that it is present) he or she should rate the most likely, objective severity of the symptoms. In patients denying or exaggerating symptoms information from other persons (parents, partner, staff) should also be used to get to the truth as much as possible. As described above a symptom may consist of different dimensions (frequency, duration, intensity) which has to be integrated by the interviewer into one compound score. However,

symptoms (depressive thought, anxieties) should not be mixed with the degree of social impairment which is rated separately.
At the end of the SIAB-EX the interviewer is asked to code whether or not organic brain disorder, schizophrenic or schizo-affective psychoses or a substantial physical illness is or was present. The assessment of these questions are necessary for a positive diagnosis of a major eating disorder. If there is any information that organic brain disorder, schizophrenia or schizo-affective psychoses or a substantial physical illness is or was present, please explore in detail and distinguish its relationship to the eating disorder. Is the eating disorder causally linked to the other mental or physical illness or is it cooccurring? Are some of the problems the patient reports a cause or a consequence of the eating disturbance?
Depending on the extent of disturbed behavior and feelings of the proband the interview will take 30 to 60 minutes.

2.3 Scoring of the SIAB-EX

Items in the interview contain codes from which the information can be derived, whether the item is essential for DSM IV (D) and ICD 10 Research Criteria (IR) diagnostic classification. Items which have no direct relevance for DSM IV or ICD 10 diagnostic classification have no such code. Items contained in one of the six components of the SIAB-EX are marked with FP1, FP2, FP3, FP4, FP5, FP6 and with FC1, FC2, FC3, FC4, FC5, FC6 for the past and the current structure, respectively. This enables the user to conveniently calculate the sum scores for each of the six SIAB-factors by hand (adding up the scores the patient has for the present status (last three months) or past for each factor. Scoring sheets are provided as a convenient way of doing this. On the scoring sheets items are tabulated by factor to which they belong. The ratings from the interview are copied to the scoring sheet and summed up. Some ratings have to be modified before being entered into the coding sheet (e. g. the body mass index is classified in certain categories before being entered into the sum of the factor) which is described on the scoring sheet. Please see figure 1 for an example.

Insert figure 1 about here

For the computation of the sum scores and for diagnostic classification according to DSM-IV and ICD-10 computer algorithms are available. Generally in items which are coded from 0 to 4 values of 2, 3 or 4 are considered to meet the diagnostic criteria.
In a sample of 82 patients the frequency of eating disorder diagnoses according to DSM-IV or ICD-10 was compared (see table 1).

Insert table 1 about here

An atypical eating disorder according to ICD-10 (F50.1) was given when criteria A-D of anorexia nervosa were met but not exclusion criterion E (criteria A and B of bulimia nervosa not met). Regarding defined diagnoses, 15 persons (18.3%) received different current diagnoses in the DSM-IV and ICD-10. Three persons with anorexia nervosa according to DSM-IV and 5 persons with bulimia nervosa according to DSM-IV received no eating disorder diagnosis according to the ICD-10. On the other hand one person with atypical anorexia nervosa and 5 persons with bulimia nervosa according to ICD-10 received no eating disorder diagnosis according to DSM-IV. One persons was diagnosed differently in DSM-IV (anorexia nervosa) and in ICD-10 (bulimia nervosa). Referring ot the past symptom expression 2 persons with anorexia nervosa and 1 person with bulimia nervosa according to

DSM-IV received no eating disorder diagnosis according to ICD-10 while 1 person with atypical anorexia nervosa and 3 persons with bulimia nervosa according to to ICD-10 received no eating disorder diagnosis according to DSM-IV. One person as diagnosed as anorexia nervosa in DSM-IV and as bulimia nervosa in ICD-10.
With 81.7% (current) and 90.3% (past) of the diagnoses being the same in DSM-IV and ICD-10, both classification systems can be considered as being well in agreement. Dropping the diagnosis atypical anorexia nervosa (ID-10), however, lowers agreement to 70.7% (current) and 635% (past).

2.4 Interpretation of the SIAB-EX

Diagnoses derived from the SIAB-EX are clinically valid evidence for an eating disorder. High sum scores of the subscales are an important indication for the presence of an eating disorder and comorbidity (depression, anxiety). Attention should be paid that current time and past do not overlap but are separate time periods. When rating the past symptom expression no consideration must be given to the last three month while when rating the current status only information on the three last months is considered. For a lifetime rating (worst ever) the maximum of the current and past symptom expression should be used.

2.5 Statistical data on the SIAB-EX

2.5.1 Objectivity of the SIAB-EX

Keeping to the general rules for conducting clinical interviews (e. g. establishing a good working relation, empathy, keeping a professional distance to the proband) will ensure the objectivity of the SIAB-EX. Extensive instructions for conducting the interview with operationalized definitions of the constructs involved will help to conduct the interview objectively. Analysis of the results is strictly standardized and as a rule will be made by using computer algorithms. No analysis and diagnostic classification is subject to interpretation by the interviewer. Norms for clinical groups will guide interpretation of the results of the SIAB-EX.

2.5.2 Reliability of the SIAB-EX

Interrater reliability

SIAB-EX interviews with 31 in-patients were recorded on video tapes and rated from the videotapes by at least one rater. A total of seven raters participated in this study of interrater reliability. As most tapes were rated by more than two experts, a total of 116 complete interview ratings was analyzed. Mean kappa values were .64 (current) and .63 (past) for the 5-point scales (range of 0-4) for all items included. Recoding the ratings into a dichotomous rating with 0 (recoded from 0 or 1 = clinically not relevant) or 1 (recoded from ratings 2, 3 or 4 = clinically significant) resulted in mean kappa values of .81 (current) and .85 (past) showing good diagnostic reliability. Details on the kappa values are listed in tables 16 and 17.

Subscale intercorrelations

Subscales of the SIAB-EX showed moderate intercorrelations (table 2).

Insert table 2 about here

All subscales correlated highly with the total score with the exception of atypical binges. This scale showed only little or for current no correlation with the total score, as well as with the other subscales. The subscale bulimic symptoms also showed low correlations with other subscales of the SIAB-EX. Low intercorrelations confirm the usefulness of the subscale structure of the SIAB-EX.

Internal consistency

Cronbach's alpha was computed for the subscales of the SIAB-EX (see table 3). The coefficients were high and comparable for current and past status. Coefficients laid between 0.52 (inappropriate compensatory behavior etc. now) and 0.93 (bulimic symptoms now and past, total score past). The total score's (now) alpha was also very high (0.92). The subscale bulimic symptoms and the total score are remarkably consistent factors. Lower coefficients (0.64 past and 0.52 now) were found for the subscale inappropriate compensatory behavior to counteract weight gain, fasting and substance abuse. This subscale seems to be more heterogeneous. Reasons may be that 1) this scale integrates diverse areas of behavior as the name of the subscale implies, and 2) compensatory behaviors differ considerable among themselves.

Insert table 3 about here

Dependence of the results of the SIAB-EX on proband characteristics

Table 4 gives an overview of the correlations of the SIAB-EX subscales with body weight (body mass index), duration of eating disorder, age and school education of the probands. There was no relevant influence of age, school education and duration of illness on the results of the SIAB-EX subscales for current and past symptom expression. Body weight, however, correlated negatively with the subscale body image and slimness ideal. This was not unexpected.

Insert table 4 about here

2.5.3 Validity of the SIAB-EX

Validity study using the Eating Disorder Examination (EDE)

Cooper & Fairburn (1987) have introduced the Eating Disorder Examination (EDE) as an expert interview for exploring disturbed eating behavior. In our study we used the 12th edition (Fairburn & Cooper, 1993) which we translated into German. The EDE comprises 34 items which are the basis for four subscales which were built based on theoretical considerations (restraint, eating concern, shape concern, and weight concern). Some further items for diagnostical purposes are included. Instructions are given for diagnostical classification according to DSM-IV. Possibler diagnoses are anorexia nervosa (without type specification), bulimia nervosa (without type specification) and binge eating disorder as the only eating disorder not otherwise specified. Criteria for binge eating disorder differ from the criteria listed in the appendix of the DSM-IV. Instructions of each interview for defining diagnoses were closely followed. As the EDE covers only the four weeks preceeding the interview comparisons were made only with the SIAB-EX ratings for the current state.

Design

80 eating disordered patients (77 women, 3 men) were assessed shortly after admission for inpatient treatment in the Klinik Roseneck, using the SIAB-EX and the EDE. The interviews were conducted in separate sessions and in order to control for the effects of sequence the sequence was varied systematically. Half of the patients was first interviewed using the SIAB-EX and then by using the EDE, while the other half of the patients was interviewed first by the EDE and then by the SIAB-EX.

Sample

The average age of the patients at admission was 28.8 ± 9.5 years (mean ± standard deviation) and the body mass index was 22.8 ± 11.0.

Results
Effects of sequence of the interviews
Analyses of variance were calculated to analyse possible sequence effects of the interview presentation. No sequence effects were observed.

Comparison of SIAB-EX and EDE

Because the EDE covers only the present state (4 weeks and sometimes 3 months) data are reported only for the present state.
Table 5 gives an overview over the correlations between the subscales of the SIAB-EX and the EDE. High correlations were observed between SIAB-EX body image and slimness ideal and EDE restraint, EDE shape concern and EDE total score; between SIAB-EX general psychopathology and social integration and EDE eating concern, EDE shape concern and EDE total score; between SIAB-EX bulimic symptoms and EDE restraint; between SIAB-EX inappropriate compensatory behavior to counteract weight gain, fasting and substance abuse and EDE restraint and EDE total score; and between SIAB-EX total score and all EDE scales with the coefficient of EDE weight concern being somewhat lower. There is a remarkably low correlation between SIAB-EX bulimic symptoms and EDE restraint. Evidently SIAB-EX sexuality and SIAB-EX atypical binges address areas which are not covered by the EDE.

Insert table 5 about here

Agreement between SIAB-EX and EDE regarding the diagnostic criteria and the diagnoses anorexia nervosa and bulimia nervosa according to DSM-IV is shown in table 6.

Insert table 6 about here

Comparing SIAB-EX and EDE the diagnosis of bulimia nervosa showed more discrepancies between interviews than the diagnosis of anorexia nervosa. Criteria A and C of bulimia nervosa were most frequently discrepant, indicating that the discrepancy in defining the frequency of binges according to DSM-IV between both interviews is most likely a reason which can explain the discrepancy. While the EDE defines the frequency of binges as at least 12 episodes in the last 3 months without a symptom free interval which exceeds 2 weeks, the SIAB-EX's definition closely adheres to the wording of the DSM-IV.
According to the SIAB-EX computer algorithm for DSM-IV diagnoses (in paranthesis diagnosis according to the EDE) 15 patients had anorexia nervosa (10 AN, 2 BN, 3 no diagnosis), 21 patients had bulimia nervosa (13 BN, 2 AN, 6 no diagnosis), 4 had binge eating disorder (1 BN, 3 no diagnosis), 14 patients had an eating disorder not otherwise specified (6 BN, 1 AN, 7 no diagnosis) and 12 had an eating disorder syndrom not described in the DSM-

IV with a lesser degree of symptom severity (2 AN, 2 BN, 8 no diagnosis), and 14 mainly obese patients with disturbed eating behavior received no SIAB-EX diagnosis (1 BN, 13 no diagnosis). These data demonstrate that the SIAB-EX in comparison to the EDE allows for a more differentiated diagnosis of eating disorders.
We also calculated correlations of SIAB-EX (current) items and EDE items (see tables 7 to 13). Correlations were not calculated for the SIAB-EX subscales general psychopathology, and sexuality and social behavior because their content is not directly related to EDE items and subscales. Before the calculation of correlation coefficients values were dichotomisized to 0 (not clinically relevant) and 1 (clinically relevant) following the instruction of the SIAB-EX or the EDE. For reasons of space we comment here only on the higher correlations ($\geq$ .50) or on specific pattern of correlations. EDE food avoidance showed high correlations with most items of the SIAB-EX body image and slimness ideal subscale, especially with the similar items qualitative reduction of food intake (12) and setting caloric limits (13). High correlations were also found between EDE food avoidance and items of the SIAB-EX subscale inappropriate compensatory behavior to counteract weight gain, fasting and substance abuse (especially item 11 quantitative reduction of food). A similar pattern evolves for EDE dietary rules, this item showing high correlations with SIAB-EX items 11, 12, and 13 (table 7). EDE fear of losing control over eating correlated highly with SIAB-EX loss of control (26) and self induced vomiting (35). EDE eating in secret showed close relationship to the items of the SIAB-EX subscale bulimic symptoms (especially frequency of binges (23 and 24) and self-induced vomiting (35)). (cf. table 8). There were no higher correlations between the items of the EDE subscales weight concern (table 9) and shape concern (table 10) and the SIAB-EX items. This may be due to the lack of definitional criteria for the severity rating of the EDE. High correlations were observed for EDE objective bulimic episodes and the items of SIAB-EX bulimic symptoms. Further EDE items covering objective binges also showed high correlations. For EDE items covering subjective binges and overeating no high correlations were found with SIAB-EX items including those referring to atypical binges (table 11). This is an indication that there is good agreement for objective binges. However, other concepts for binges like subjective binges, atypical binges or overeating refer to different behaviors. For subjective binges this difference may be caused by different definitions in the interview.The SIAB-EX defines subjective binges according to the rating of the proband concerning the amount of calories consumed while the EDE defines subjective binges as binges (comparable to objective binges) without the feeling of loss of control. EDE dietary restriction outside bulimic episodes correlated highly with SIAB-EX weight phobia (7) and SIAB-EX quantitative reduction of food (11). EDE items covering self-induced vomiting showed high correlations with the items of SIAB-EX subscale bulimic symptoms as well as with item 24 (frequency of binges 6 months). Close relationship was found between the items which cover in the SIAB-EX and the EDE laxative abuse (table 12) and excessive physical exercise (table 13).

Insert tables 7 – 13 about here

Conclusion regarding the comparison of SIAB-EX and EDE

SIAB-EX and EDE differ in some important aspects:

1. The EDE covers exclusively symptoms related to eating disorders. The SIAB-EX, however, includes many questions covering non-eating specific psychopathology which is often found in eating disordered persons (e. g. depression, anxiety, substance abuse).
2. While both interviews cover DSM-IV diagnoses of anorexia nervosa and bulimia nervosa the SIAB-EX definition of binge eating disorder adheres more strictly to the criteria

described in the appendix of the DSM-IV. The computer algorithm of the SIAB-EX diagnostic program also offers operationalized criteria for subtypes of anorexia and bulimia nervosa as well as for all types of eating disorder not otherwise specified according to DSM-IV as well as some further eating disorders syndromes not described in the DSM-IV. Generally the wording of the SIAB-EX closely follows the formulation of the DSM-IV. As an additional option the SIAB-EX can be used for diagnostic classification according to ICD-10.

3. While the EDE covers for most items the time period of the 28 days preceding the interview, the SIAB-EX current version covers the preceding three months (which is more in accordance with DSM-IV criteria) and also offers the possibility for past (excluding current) as well as lifetime assessment for certain research questions like epidemiology or assessing the phenotype in genetic studies, as has been done with the SIAB-EX in the genetic project of the Price Foundation (Kaye et al. submitted).
4. For the SIAB-EX there exist for each item clear-cut definitions of symptoms and criteria as well as case examples, and anchoring points are supplied. Computer algorithms for diagnoses and sum scores are available.

Comparison of the SIAB-EX with self-rating measures

The SIAB-EX was compared to the Eating Disorder Inventory (EDI-2; Garner, Olmsted & Polivy, 1983; Garner, 1991), the Three Factor Eating Questionnaire (TFEQ; Stunkard & Messick, 1985), the Hopkins Symptom Checklist (SCL-90-R; Derogatis, Rickels & Rock, 1976) the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), and the PERI-Demoralization Scale (PERI-D; Dohrenwend, Shrout, Egri & Mendelson, 1980). All self-rating questionnaires referred to the current status. Results are listed in tables 14 and 15.

Insert tables 14 and 15 about here

Convergent validity

The SIAB-EX subscale body image and slimness ideal was expected to show a close relationship with EDI drive for thinness, EDI body dissatisfaction and TFEQ cognitive control. Indeed were the correlations between SIAB-EX body image and slimness ideal and EDI drive for thinness as well as TFEQ cognitive control the highest. The coefficient of SIAB-EX body image and slimness ideal and EDI body dissatisfaction, however, was negative.

SIAB-EX general psychopathology was found to show close relationship to the sum scores of the BDI and PERI-D, to EDI total score, EDI inefficiency adn EDI social insecurity, and less relationship to eating disorder specific scales. Correlations with SCL-90 subscales were lower but showed a plausible pattern. SIAB-EX sexuality (and social integration) evidenced close relationship to BDI and PERI-D. SIAB-EX sexuality (current) also showed high correlations with EDI inefficiency and EDI maturity fears. SIAB-EX sexuality and social integration (past) showed a close relationship to most of the personality related scales of the EDI.

SIAB-EX bulimic symptoms showed high correlations with EDI bulimia, TFEQ disinhibition and TFEQ hunger.

SIAB-EX inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse (current) was found to have a close relationship to EDI drive for thinness, EDI interoceptive awareness, TFEQ cognitive control and the BDI, while there were low correlations with EDI impulse regulation and EDI bulimia. For the past status SIAB-EX inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse was found to correlate highly with EDI drive for thinness, EDI bulimia, EDI interoceptive

awareness, EDI impulse regulation and TFEQ cognitive control. Low (past) or no (now) correlations were found between SIAB-EX inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse and TFEQ disinhibition, while the BDI correlated for both time points with this SIAB-EX subscale.
SIAB-EX atypical binges showed moderate correlations with EDI bulimia, EDI body dissatisfaction and – negatively – with TFEQ cognitive control. Closer relationship was found with TFEQ disinhibition and TFEQ hunger.
These results confirm the convergent construct validity of the empirically derived SIAB-EX subscales. Bulimic behavior is well differentiated from inappropriate compensatory behavior, body image disturbance and slimness ideal.

Discriminant validity
Low correlations were found between the subscales of the SCL-90 and all subscales of the SIAB-EX except general psychopathology. BDI and PERI-D correlated with all SIAB-EX scales except atypical binges. Stronger relationships were found between depression and demoralization and SIAB-EX general psychopathology, although depression seems to be related to most eating disorder symptoms. EDI bulimia did not correlate with SIAB-EX body image and slimness ideal, but showed a high correlation with SIAB-EX bulimic symptoms. These two SIAB-EX scales seem to be separated fairly well.
It is highly plausible that most personality related subscales of the EDI showed the highest correlations with SIAB-EX general psychopathology. Expectedly TFEQ disinhibition and TFEQ hunger were related only to SIAB-EX subscales referring to eating binges.

2.5.4 Normative information

Tables 16 to 19 give results on a clinical sample of 377 inpatients (11 males, 366 females) which were treated for an eating disorder. Data were collected shortly after admission to inpatient treatment. Mean age at admission was 29 years. Body mass indes was 26.0. At intake 60 persons fulfilled the criteria of anorexia nervosa and 97 persons fulfilled the criteria of bulimia nervosa according to the DSM-IV. Data on 111 healthy women from the community with a mean age at the time of the interview of 21 years and a mean body mass index of 20.3 are also supplied.

Insert tables 16 to 19 about here

3. Instructions for the SIAB-EX expert interview

3.1 Definitions, operationalizations and case examples for each item of the SIAB-EX

1./2. Deviance from Normal Body Weight

Calculate the Body Mass Index (BMI) for standardization of body weight. BMI is of relevance for the diagnosis AN, BN, BED and ED-NOS according to the computer algorithm. The formula for calculating is:

$$\text{BMI} = \frac{\text{weight in kg}}{(\text{height in m})^2}$$

For lifetime lowest weight since the person was „grown up“ calculate:

$$\text{BMI} = \frac{\text{lowest weight ever in kg}}{(\text{height at the time of lowest weight in m})^2}$$

A BMI or 21-23 is usually considered normal. There exist tables and graphs from population studies which give the average BMI for a certain age group. For calculating the percentage of under-/overweight use the relevant graph or table as reference for „normal BMI“ and calculate the percentage the interviewee's body weight deviates from this (e.g. 15 % below average (BMI) weight yes/no).

We advise the user to take sex and age into account when calculating the body mass index. There exist graphs and tables which can be used for this purpose. Hebebrand et al. (1994, 1996) have published normes (percentiles) separately for males and for females for a large German sample and Hammer et al. (1991) have done the same for a large sample of North American adolescents. Taking age and gender into account when calculating the percentage of deviation from the normal weight will lead to more accurate weight estimates. This procedure is recommended in the SIAB-EX.

In some cases the specific normal weight of a certain individual can be explored in a detailed weight history, but in clinical practice this is frequently not possible.

3. Internal achievement orientation

Probes: What was your **main occupation**? Your **present occupation**? **How well did you perform at school, at work or in your household? How satisfied were you with your achievements? How dependent was your self-esteem upon achieving at school, work etc.?**
Additional Probes: Did you work overtime or spend much time doing homework? How often? Were you proud when you achieved a good result? How did you feel, when you left things unfinished? How did you feel when you failed? How would failure affect you (e.g. distressed for an extended period of time)? Did any other areas in your life suffer because you were working such long hours at work/school? Were there other areas besides work or school in which how well you did was very important for you?

Definition: In order to have a basis for rating this item please ask what the person is doing (school, work, household?) and how well she or he is able to perform tasks in those areas and how satisfied the person is with his or her achievements. It is helpful to explore specific examples and facts. Does the person work long hours? Does the person attend school or college study much of the time, even on evenings, weekends and during vacation? Another level which should be taken into consideration is, how does the person perceive his or her achievement. Reports of the satisfaction with one's own achievements frequently is an indication of internal achievement orientation. High achievement is not necessarily equivalent to high internal achievement orientation. Internal achievement orientation can be assumed to be present when the person does a lot to achieve what he or she does achieve. If a person shows high achievements only under external pressure, internal achievement orientation may not necessarily be present, but it may be hidden and disguised. Another aspect of internal achievement orientation is the motivation behind it. Does the person put in a lot of work efforts to get recognition from others? In this case achievement orientation would be rated as being present.

Some persons may report that they have achieved only to fulfill their duty. Further probes will elucidate whether they are only doing their duty or if they have accumulated a lot of duties and responsibilities, because they therefore get direct or indirect recognition, which may enhance their self-esteem (indication for presence of internal achievement orientation). Some persons may work a lot because of obsessive compulsive traits. Perfectionism can be linked with internal achievement orientation but is not necessarily so. Obsessive compulsive symptoms are rated on items 56 to 59. In the following paragraph guidelines are given for the ratings on a scale from 0 to 4.

Persons may not show increased internal achievement orientation and overachievement in usual areas (school or work), but may have very special areas of interest, in which they show high internal achievement orientation. For example a student may not care about his or her grades but may have high

internal achievement orientation and overachievement as a bicycle racer. In this case, internal achievement orientation would definitely be rated as present. How high it is rated would depend on the intensity of input into the special area of interest, dependence of self-esteem on achievements in this area and interference with other important areas of life.

Code 0 = No signs of increased achievement orientation. The person is convincingly satisfied with his or her achievements. Persons who show a subnormal internal achievement orientation should also be scored as 0. Persons in this category only show a mild or transient irritation following failure.

Code 1 = Slight elevation of achievement orientation. The person does a bit more than usual or necessary (e.g., stay sometimes (a couple of days per month) longer at work and tries to do his or her work very well). The person can easily cope with the slightly elevated internal achievement orientation and has no major problems in leaving things unfinished at times. Failure has only slight effects on the person.

Code 2 = Marked elevation of achievement orientation: The person quite frequently works harder than necessary (e.g., works long hours about one day per week). The self-esteem of the person is to some extent dependent on having achieved something worthwhile or getting recognition for achievement. The person shows a markedly increased input into work or areas that are relevant for achievement, and other areas (e.g., family life) suffer to some degree from that. Failure affects self-perception, mood or self-esteem and cannot be coped with quite easily.

Code 3 = Strong elevation of achievement orientation: The person works a lot more than necessary (e.g., works long hours regularly two to three days a week; has a bad conscience when not working (evening, weekend, vacation); volunteers to work on weekends or even during vacation without true external necessity). Self-esteem of the person is strongly dependent on his or her achievement. The person is seldom content with his or her own achievement. Other areas of life clearly suffer from the high input into areas relevant for self-esteem and achievement. Failure to achieve strongly affects self-esteem and mood and is not easily coped with.

Code 4 = Very strong elevation of achievement orientation. The person almost always puts in a lot of effort and time in order to achieve something (e.g., working long hours about every week-day; has sacrificed vacations in order to work in some achievement relevant area; regularly works not only on week-days but also on weekends and holidays). The self-esteem of the person is highly dependent on having achieved something. The person is hardly ever content with his or her own achievements and has serious problems in coping with the increased work load resulting from the high achievement orientation. Other areas of life suffer severely from the high work input and achievement orientation. The person can hardly do anything without the pressure to achieve. Self-esteem and mood are severely affected by failures. Experiences of failure lead to longer periods of irritation and distress.

4. Anxieties

Probes: Did you feel generally tense, nervous, anxious, fearful or afraid? Have you experienced panic without any obvious reason? Were there certain objects or situations that you were afraid of? (Interviewer: code fear of certain objects or situations under phobia.)
Additional probes: Were you worried about something that might happen in the future? About what? How pervasive and frequent were these worrisome thoughts? Did you have panic attacks? Where you were hit with a wave of anxiety out of the blue which may have been accompanied by symptoms such as trembling, sweating, hyperventilation or chest pain, as well as the feeling that you may have a heart attack or even die? How often did you have these attacks and with what consequences? To what degree did you feel impaired by your anxieties? How often did they occur? Did you avoid anxiety-provoking situations?

Definition: By anxieties here different kinds of fears are meant such as fears associated with physical symptoms, anxious thoughts, anxieties, which may be associated with panic attacks, and hypochondric fears, such as worrying about somatic functions, or pathological fears of having a certain illness. Excluded from the rating of this item are specific phobias (which are rated in the next item). Also, fear of getting fat (see item 7) or fears associated with obsessive-compulsive symptoms (items 56-59) are also not rated under this item which assesses more general anxieties.

Code 0 = No excessive fears.

Code 1 = Slight excessive fears: The person gets anxious easily which may be associated with a milder expression of physical symptoms frequently associated with anxieties, such as pulpitations of the heart. The person can cope with the fears and shows no impairment in daily activities from the fears.

> Example: A married, 45 year old woman came to therapy because of premenstrual symptoms. In association with premenstrual tension she showed some increase of her anxiety level in the three or four days preceding menstruation. She felt tensed at times and occasionally felt uneasinesss and general anxiety; however, even when this occurred she did not withdraw but continued her daily activities. She noticed that in the evening, when she had time to relax it took her more time to calm down. She did not see a need for professional help.

Code 2 = Marked excessive fears: The person develops anxieties especially when under pressure (examinations, conflicts with partner, divorce, symptoms like sleep disturbance, nervousness), increased worries about the future may have occurred for a limited time episode or to a limited degree. In other cases the symptoms of anxiety are frequently present but do not extend to all areas of life. Because of the fears the person usually shows some impairment in his or her daily activities. For example a housewife may only be able to do her housework with special asistance and coaching from other family members.

> Example: A married, 44 year old woman, whose husband was an addicted gambler, described herself as being nervous and worrying all the time. She was mainly concerned with financial issues, which were partially realistic but also somewhat excessive. She was afraid to talk with her husband about these issues and had fears that her husband might have incurred large debts. She was afraid that their small business might go bankrupt. These anxieties about the future occurred quite a few times and were excessive since her husband had been in therapy for his gambling problem and had not shown any gambling type behaviour in the last three years.

Code 3 = Severe excessive fears: The person shows severe or frequent anxieties which may be associated with panic attacks. The anxieties may include a variety of different areas of life. There are usually strong somatic symptoms associated with the occurrence of the anxieties (e.g. pulpitations, sweating). As a result of the fears the person shows some impairment in her daily activities. There is suffering from the fears.

> Example: A 50 year old divorced man has been tense and nervous for many years. Two years before the divorce six years ago his anxieties started with an excessive preoccupation about his physical health status. This persisted even though his doctors repeatedly told him that he was physically healthy. As a war veteran he lived from a pension. More recently his anxieties became generalized and he reported "All of a sudden I am fearful without any reasons. When other people ask me "What are you afraid of?" I can't answer it." About one out of four episodes of anxiety were associated with panic attacks. He then was afraid of totally losing control and that something terrible might happen. During his anxiety attacks he felt his heart pounding, realized irregularities in breathing (stopping to breath and then sighing). In association with his

anxieties he also suffered from diarrhea. Tranquilizers were only of temporal help and he intended to increase the dosage.

Code 4 = Very severe excessive fears: The person has very strong and/or persisting anxieties which can be associated with panic attacks. Anxieties are associated with very intense physical symptoms (pulpitation, sweating, trembling). The very severe anxieties may have had a profound impact on the person's level of functioning and there may be severe impairment at school, work, household or leisure time activities. The intensity of the fears is very high and/or the fears occur very frequently.

5. Phobias

Probes: Did certain things or situations make you feel tense or anxious? Examples are being alone at home, going out alone, travelling by bus or train, big animals, insects, height or darkness or being in front of a group of people?
Additional probes: If indications for phobias exist: how serious were these phobias? How often did they occur? Did you try to avoid situations which provoked your phobias? What if any impairment did the phobias cause? How distressing were they? Do you believe that you were much more afraid in this situation than most people?

Definition: Phobias are defined as fears of specific objects or situations, which objectively are not dangerous or threatening. While anxieties (item 4) can be vague and general, phobias are very specific (claustrophobia, acrophobia, agoraphobia etc.). The rating of 2, 3 or 4 should only be used, when the phobia appears to be of some clinical relevance. A phobia is recognized by the person who experiences it as excessive or unreasonable. People handle phobias quite differently. Some tend to avoid the phobic stimulus while others don't. In the following rating please rate the severity of the phobic symptoms and the distress, suffering and impairment associated with it - irrespective of the presence or absence of avoidance behaviour.

Code 0 = No phobic symptoms.

Code 1 = Slight phobic symptoms without ony major distress or impairment in daily activities. The person may or may not avoid the phobic stimulus but when confronted with it coping is possible. The phobia is so mild that it is clinically not relevant.

Example: A married, 20 year old woman reported to her doctor fears of snakes and heights. Refering to the snakes she said "I feel uneasy, tense and anxious when I see a snake, especially when I think it might be poisonous. Even if I knew it was not poisonous I don't think I could touch it." She did not avoid any places where snakes might be, nor did her fear of snakes (and height) impair her in any of her activities. Refering to her fear of height she said: "When I don't look down, I feel OK." She avoided standing near an abyss or leaning over a high balcony, but she was able to do it without much fear.

Code 2 = Marked phobic symptoms: When confronted with a phobic stimulus marked fears usually are associated with physical symptoms (pulpitation, sweating, trembling). To some extent the phobic symptoms interfere with daily functioning (e.g. a business man, who needs to travel quite a bit, has a fear of flying and avoids flying and instead takes the train or bus, even though this is much more time-consuming). When actually confronted with the phobic stimulus the person who has some assistance or "will-power" can manage it, even though it does take some special effort.

Example: A 25 year old married man suffered from several phobias. He avoided crowded places because of the fear that he would faint. When he took a seat in a theatre he always tried to sit near the exit in case the fear of fainting occurred. He also was afraid of seeing blood and had a fear of fainting when his blood was

drawn. He showed avoidance behaviour but with some effort was able to confront himself with these situations.

Code 3 = Severe phobic symptoms: When confronted with the phobic stimulus the person shows severe distress and usually severe physical symptoms associated with it (pulpitation, sweating, trembling). Usually there is a significant impairment at least in some areas of daily activities and functioning. Frequently the person has aranged his or her life/work around the phobias, so that phobia-inducing objects or situations can be avoided. When confronted distress is severe.

Example: A 35 year old woman with a persisting mental disorder, who suffered from multiple neurotic symptoms, was afraid of darkness and being alone. When coming home from work she immediately locked the door of her appartment and did not dare to leave the appartment until the next morning, when she had to go to work. During evenings, nights and weekends, she had intense fears that somebody could break into her appartment and could harm her. She also avoided going to crowded places because she was afraid she could faint and would find this very embarrassing. Because of her fears she did not travel anywhere during her holidays and she rarely went any further than to the office where she worked and the stores where she usually shopped.

Code 4 = Very severe phobic symptoms: Confrontation with the phobic stimulus causes very intense distress including very severe physical symptoms associated with fears (pulpitation, sweating, trembling, and the person may actually have fainted once or more times when confronted with the phobic stimulus). Most people show some tendency to avoid the phobic stimulus. There may be quite a bit of impairment in daily functioning as a result of the severe phobias and possible avoidance behaviour.

Example: A single 26 year old woman had during the past year been unable to leave her house by herself. She was unable to drive the car, ride a bus or go shopping by herself. Whatever she did outside her house, somebody had to accompany her and be close to her in a store while she was shopping. Her mother, who lived next door, looked after her and the house and did most of the shopping for her or took her to the shopping mall. When her mother or other persons were not available she would not confront herself with the fear provocing stimuli and there had been times when she was not able to go to the doctor and during her mother's vacation half a year ago she had lost ten pounds because she felt unable to shop or go to a restaurant.

6. Sleep disorders

Probes: Have you ever had problems sleeping, such as difficulty falling asleep, staying asleep, or waking too early?
Additional probes: Were you restless during the night? Did you frequently wake up early and still feel tired? Did you sleep too little? For how long did your sleep problems persist? Did your loss of sleep interfere with your functioning during the day? How many hours of sleep did you miss in a bad night? (Descriptive evaluation regardless of use of sleep medication.)

The severity of a sleep disorder is rated irrespective whether or not a person takes hypnotics. What is rated is how good a person slept irrespective of medication or other circumstances. In rating, the interviewer takes into account difficulties falling asleep, disturbances of the sleep pattern, early morning awakening without feeling fresh and restored, hyposomnia, hypersomnia and other symptoms of disturbed sleep. When sleep is disturbed by frightening dreams and nightmares this is included in the rating as well. When the sleep disturbances are exclusively a result of the external condition (one's own baby crying all night) it should not be coded higher than "1". In the case of a manic episode a severe sleep disorder may be present (hyposomnia), even though the patient does not complain about it and not suffer from it.

Code 0 = No sleep disorder.

Code 1 = Slight sleep disturbance: Occasional awakening at night but the person usually falls asleep again fairly soon. Sometimes it may take up to an hour to fall asleep while the person may wake up in the morning (one hour earlier than usual). Overall the person does not feel impaired by the sleep disorder. In other cases there may by an increased need for sleep (hypersomnia) - without interfering with daily functioning or a person may not sleep very deeply and wake up from minor noises during the night or sleep can be disturbed by nightmares, however rarely.

> Example: A 38 year old married woman had during the last week problems in falling asleep and sleeping through the night during the last week because her 14 year old daughter had high fever of unexplained origin and her eight year old son, who suffered from enuresis, was using a special device which would ring a bell when he urinated while sleeping. Because of these circumstances, which were temporary, she slept about two hours per night less than she usually did and needed. Prior to these circumstances she had no sleep disturbances. Since the interruptions of sleep were due to external circumstances only and not to her own mental condition it should be rated as "1".

Code 2 = Marked sleep disturbance: Problems falling asleep, staying asleep or early morning awakening, regularly or persistently for a significant period of time (up to one or two hours sleep missing per night) or three hours of sleep lost for a period of two weeks. The person feel tired and exhausted. Or: Increased desire to sleep and needing a long time to wake up and problems getting started in the morning. Or: Being restless, waking up easily when there is some (even minor) noise, having nightmares disturbing the sleep or feeling impaired when awake as a result of sleep disturbances.

> Example: A married 49 year old man was treated for a moderatly depressive episode, which improved with homeopathic sedatives. He reported taking one pill daily and complained of problems falling asleep or going back to sleep when he woke up. Usually it took less than 30 minutes to fall back to sleep. Quite frequently he woke up at about two o'clock in the morning, fell asleep again within half an hour and then slept until six o'clock in the morning when he usually had to get up. Occasionally he has nightmares and feels confused thereafter. During the last week he awoke from nightmares on several nights.

Code 3 = Severe sleep disturbance: Problems falling asleep, staying asleep or early morning awakening regularly for a longer period of time or for two weeks consecutively. The duration of sleeplessness is up to three hours per night for a longer period of time or up to four hours per night in two weeks. The person feels considerable impairment resulting from the sleep disturbance.

> Example: A 42 year old woman sufferd from persistent anxiety and depression during her divorce. Her condition got worse after her daughter left home because they had severe quarrels with each other. The woman complained about sleep disturbances. Usually it took her up to two hours before she fell asleep, she woke up early in the morning and was unable to fall back to sleep. She always felt tired during the day. She didn't want to take any hypnotics. Since she was a cashier her work required concentration during the day and she had made some mistakes because she felt so tired during the day.

Code 4 = Very severe sleep disturbance: Very severe problems falling asleep, staying asleep or severe early morning awakening regularly for a longer period of time or for at least two weeks consecutively. If there is hyposomnia, the person reports that he or she was losing at least three hours of sleep per night. As a result of this the person feels very severely impaired during the daytime.

7. Fear of Gaining Weight or Getting Fat (Weight Phobia)

DSM IV-AN-B: Intense fear of gaining weight or becoming fat, even though underweight.

IR-AN-C2: Self-perception of being too fat, with an intrusive dread of fatness ...

IR-BN-D1: A self-perception of being too fat, with an intrusive dread of fatness (usually leading to underweight)

Probes: During times when you were especially concerned about the slimness of your body, how would you have felt, if you gained 3 - 5 kg (= 7 - 11 pounds) of weight within three months? Would this have made you anxious or panic-stricken?

Additional probes: How would you have felt if you would have gained just 1 or 2 pounds within three months? What did you do to deal with this anxiety (e.g. increase exercise or decrease food intake or purge)?

Interviewer: Are there indicators for weight-phobic behaviour?

Definition: The item aims at irrational, at times panic-level fears of anorexic, bulimic and other eating disordered patients of gaining weight or becoming fat. In anorexia nerovsa this "weight phobia" may exist even when body weight is very low. When a patient denies symptoms of an eating disorder or when concerns about social desirability prevail, this item may not be very easy to explore. It is, however, a core item for the characterization of eating disorders and it is crucial to get some idea whether or not "weight phobia" is or was present. Sometimes the symptom can be concealed even for the patient willing to report honestly, e.g. an underweight AN patient, who has kept her weight stable at 32 kg, with which she feels comfortable, a straight forward question "Are you afraid of getting fat?" might be answered with "no", because she is not under any pressure to gain weight. When the same patient is asked if she was afraid of gaining weight when her family or physician put pressure on her to gain 5 kg or more the answer might be "yes, very much". In rating this item the actual body weight (obesity, normal weight, underweight) must be taken into account. If the person is severely underweight due to anorexia nervosa this usually is an indicator that there may be a high degree of "weight phobia". An underweight cancer patient on the other hand will not have fears of gaining weight. Also, since we are not sure if underweight anorexia nervosa and "weight phobia" are really linked in all anorexic patients in different cultures body weight and fear of gaining weight should be considered and rated separately. Sometimes "weight phobia" only becomes evident after a period of significant weight gain (possibly under therapeutic pressure). In overweight persons, 2, 3 or 4 should rarely be used as a rating, since it is unlikely that the fear of gaining weight is extremely high unless the person tending to use counterregulatory measures, such as vomiting etc.

Code 0 = No fear of gaining weight.

Code 1 = Slight fear of gaining weight. Gaining a couple of kilos over about two weeks would cause some discomfort but no marked or intense fears. The person trusts his or her abilities and body metabolism to control and maintain body weight. If for some reasons a moderate amount of weight gain is unavoidable (e.g. side effect of tricyclic medication) the person would feel discomfort with gaining weight but would not be frightened. The person could accept gaining a few kg without feeling terrified or without having to change life style and habits of eating drastically. Usually there is no big discrepancy between the desired weight and actual body weight.

Code 2 = Marked fear of gaining weight: Gaining a few kg within a couple of weeks would cause marked fears and if weight gain occurred the person ususally would do something about it because of the amount of fear and discomfort experienced. Gaining weight might increase the preoccupation with body weight, slimness and eating or it might lead to some counterregulatory measures (caloric restriction, dieting, purging behaviour).

Code 3 = Severe fear of gaining weight: Even a small increase in body weight (e.g. one kg) causes intense fears (weight phobia). An anorexic patient when asked about this item might first react by saying that it would not

cause any fears to gain a bit of weight. However, when explored in more depth or if weight gain actually occurs during the course of illness intense fears may arise. These intense fears of gaining weight may result in open reports of these fears, or they could lead to counterregulatory measures, such as strict dieting, increased purging behaviour or increased physical exercise. For a person with intense fears of gaining weight, thoughts are frequently centered around body weight, slimness, caloric intake etc. A person with intense fears of gaining weight might react spontaniously to the questions of this item with expressions like: "Gaining a kilo or more would be an absolute catastrophy".

Code 4 = Very severe fear of gaining weight. Fears are so intense that the person will do almost anything to not let weight gain happen. Even minimal fluctuations of body weight (e.g. 500 gram) can cause excessive worries and may intensifiy measures to counteract weight gain, such as strict dieting, excessive physical exercise or purging behaviour. Maintaining or even reducing body weight is usually the most important issue in the life of an anorexic person. In most cases self-esteem is intensly linked with body slimness. When asked the probes for this item the patient may show extreme reactions, such as "If my weight would really increase markedly, I don't think I could deal with this; if I would have the courage to do it, I might put an end to my life".

8. What is your prefered body weight?
IR-AN-C3: Self perception of being too fat ... leads to a self-imposed low weight threshold

9. What was your lowest prefered weight ever?
IR-AN-C3: Self perception of being too fat ... leads to a self-imposed low weight threshold

10. Dependence of self-evaluation and self-esteem on body shape and weight
DSM IV-AN-C2: ... undue influence of body weight or shape on self-evaluation ...
DSM IV-BN-D: Self-evaluation is unduly influenced by body shape and weight

Probes: How dependent was your self-evaluation and self-esteem upon your body shape or weight?
Additional probes: How did you generally feel about yourself when you „felt fat“ vs. when you „felt thin“? Were there other areas in your life from which you could draw your sense of worth? If yes, rank order how important body shape and weight was upon self-esteem in comparison with these other areas.

Definition: In many patients the answer to that item is closely linked to those of item 7 (fear of gaining weight (weight phobia)). Questions should be asked which elicit the association between maintaining body weight/reducing body weight on the one hand and self-evaluation and self-esteem on the other hand. Quite a few eating disordered patients have made the slimness of their body one of the central issues in their life. If they achieve their aims they feel good, if they don't, self-evaluation is negatively affected. The item should be rated according to the extent to which self-evaluation is negatively affected, when personal aims concerning body shape or weight are not achieved.

Code 0 = No unusual or pathological dependence of self-evaluation on body weight and shape.

Code 1 = Self-evaluation depends slightly on achieving one's own aims concerning body shape or weight. Frequently persons have an ideal image of how their body should look like and some parts of the body (buttocks, thighs) may be thought to deviate more from this ideal than other body parts. While the person does several things to lose weight and to bring her body weight closer to her ideal body image, school, work or recreational activities usually are not negatively affected by this slight dependence of self-evaluation on figure slimness or weight.

Code 2 = Marked dependence of self-evaluation on figure (slimness) or weight.

Code 3 = Strong dependence: Body shape or weight have profound influence on the person's self-evaluation. The person feels inferior, other positive qualities are disregarded or he or she may avoid exposing her body to others (e.g. swimming pool), when personal aims of body slimness and body weight are not achieved. Usually thoughts very much center about body shape or weight and self-esteem and self-evaluation is profoundly associated with it. Other problems in life are frequently neglected and thoughts frequently center on the issue of body shape or weight.

Code 4 = Very strong dependence: Self-evaluation is very severely affected by body shape or weight. When the aims of slimness and body weight are not achieved and when the person feels fat severe feelings of worthlessness and self-devaluating thoughts are triggered. Frequently the person believes that all her problems would dissolve if only her figure and weight were OK according to his or her own standards and ideal images.

11. Dieting or Fasting (Quantitative Food Reduction)

Probes: Have you dieted or restricted food intake? Did you count calories? Did you try to eat as little as possible or less than your body would have needed to keep a stable weight? Did you diet or fast during the day as long as possible or to eat only in the evening?
Additional probes: For how many hours a day would you go without eating? How often? For how long did this pattern persist? Did you go without eating for more than 8 hours during the day in order to diet? Have you skipped meals in order to reduce your caloric intake?

Definiton: Eating disordered persons often try not to eat anything at all for a defined period of time (skipping breakfast and lunch and only eating in the evening) or may deside to have meals regularly but eat only very small amounts. In this item the quantitative reduction of food intake is rated (irrespective of the qualitative composition of the food ingested, which is rated in the following item 12). For rating the answers to this item on quantitative food reduction it should be taken into account what a normal person of the same sex, age and height living under similar circumstances would eat. Some persons will have counted their caloric intake per day in detail which - if counted correctly - makes it easy to rate this item. For persons who have not counted their caloric intake ask probes the answers to which give you a good impression what the person in comparison to a non-eating disordered person has been eating.

Code 0 = No quantitative reduction of food intake.

Code 1 = Slight reduction of food intake: A person with slight reduction of food intake may report a) a short episode of intake of 1200-1600 kcal per day (less than two weeks) or b) a small reduction of the food intake to 1600-2000 kcal per day occasionally, while during most times caloric intake is not reduced.

Code 2 = Marked quantitative reduction of food intake: a) food intake is reduced continuously over a longer period of time to 1600-2000 kcal per day or b) the person has dieted or reduced food intake by other means to 1200-1600 kcal per day up to three weeks duration or c) the person may have reduced food intake fairly drastically to 800-1200 kcal per day for at least two weeks or d) is regularly missing certain meals (e.g. breakfast, lunch) in order to reduce caloric intake; f) when food intake has been reduced to half the normal intake for at least three weeks this is coded as "2".

Code 3 = Severe reduction of food intake: a) food intake is reduced to 1200-1600 kcal for longer periods of time (months or more) or b) the person frequently and repeatedly has made strict diets for a couple of weeks or more, reducing food intake to about 800-1200 kcal or c) two weeks or more with very low calorie diet (800 kcal or less) or d) regularly skips one or two meals and has therefore severely reduced food intake for longer periods of time (weeks or months).

Code 4 = Very severely quantitative reduction of food intake: a) daily food intake is below 1200 kcal for long periods of time (several weeks, months) or b) very frequent, continuous or multiple diets for three weeks or more with very low caloric intake (below 800 kcal) or c) having only one meal per day over long periods of time and reducing food intake severely by this timing of food intake.

12. Avoidance of Fattening Food and Selective Eating (Qualitative Food Reduction)

IR-AN-B: Self-induced weight loss by avoiding "fattening foods"

Probes: Have you tried to avoid certain high caloric foods, that you enjoy eating? Did you avoid it in order to remain or become slim?
Additional probes: Did you intentionally eat less fat or carbohydrates in order to stay or get slim? Did you restrict the range of your food (e.g. no sauces, no butter)? What types of food were avoided? What types of food did you allow yourself to eat?

Definiton: This item should evaluate to what degree the patient avoids "fattening" food and limits the variety of food he or she normally eats (with the exception of binging attacks) for fear of gaining weight. The following criteria are to be considered: How many different kinds of food are avoided? How conscientious is the person in avoiding certain (expecially "fattening") foods?
Note: Restriction due to clear medical conditions (e.g. true allergies or diabetes) should not be rated as food avoidance.

Code 0 = No selective eating or qualitative food restriction.

Code 1 = Slight selective eating: Variety of food is not limited, but the person tries to eat more "healthy", i.e. eats more salad, vegetables and fruits instead of "fattening" foods. These so-called "healthy" foods replace chocolate and sweets, the basic foods are eaten in sufficient amounts. The person pays attention to fat and caloric content, but he allows himself to basically eat everything. Occasional "sins" are allowed.

Code 2 = Marked selective eating: The variety of food eaten is restricted by avoiding fat and sugar, consistantly eating only products with little fat content and few calories. Fatty sausages and cheese are replaced by "light" products, such as diet margarine. Products with sugar are avoided and replaced with products containing artificial sweetening. Candy and cake are clearly avoided.

Code 3 = Severe selective eating: The variety of food is restricted by avoiding fat, sugar and carbohydrates. More and more basic foods are replaced by salad and vegetables. Fat and sugar are eliminated as much as possible.

Code 4 = Very severe selective eating: The variety of food is reduced to a minimum. Only a few low-caloric foods may be eaten (salad without dressing, steamed vegetables, lean protein products, etc.). Fat, sugar and carbohydrates are "forbidden". Very one-sided diets are also coded with "4".

13. Restrictions of Caloric Intake

Probes: Did you try to set a limit to your caloric intake?
Additional probes: What was your lowest limit in calories per day at the time when you were restricting the most?

Definition: This item inquires about the person's decision to limit the amount of food/calories consumed per day, independent whether or not this can be adhered to by him- or herself. Limits are set in order to remain slim or to get slimmer.

Diets lasting for a longer period of time should be evaluated according to the amount of food reduction, the limitation of the variety of the food and the caloric limitation and be correspondingly coded in a item from 11 to 13.

Code 0 = No caloric limitation.

Code 1 = Slight caloric limitation: The daily caloric intake is limited to between 1600 and 2000 calories. An alternative would be a one-time diet with a caloric limit between 1200 and 1600 calories for a maximum of two weeks with otherwise normal eating behavior.

Code 2 = Marked caloric limitation: The daily caloric limit is between 1200 and 1600 calories. An alternative would be occasional diets with a caloric limitation between 800 and 1200 calories or a one-time diet with a caloric limit under 800 calories for a maximum of two weeks.

Code 3 = The daily caloric limit is between 800 and 1200 calories. An alternative would be occasional diets with a caloric limitation of under 800 calories.

Code 4 = The daily set caloric limitation is under 800 calories.

14. Chewing and Spitting out Food

D-EDNOS-5

Probes: Have you put food into your mouth, chewed it (without swallowing) and spit it out again in order to reduce caloric intake?
Additional probes: If yes, how often at its most frequent?

Definiton: Chewing of food without swallowing it and spitting it out afterwards in order to avoid intake of calories. Vomiting is not counted in this item. Since vomiting and spitting out food can be confused by the patient, the interviewer must explore this explicitly.

Code 0 = No spitting out of food.

Code 1 = Rarely spitting out (up to once a month).

Code 2 = Sometimes spitting out of food (up to once a week).

Code 3 = Frequently spitting out (up to once a day).

Code 4 = Very frequently spitting out of food (more than once a day).

15. Regurgitation of Food

Probes: Have you swallowed and then regurgitated food in order to chew it again?
Additional probes: Did you do this to avoid gaining weight? If yes, how often at its most frequent?

Definition: Swallowed food is regurgitated and chewed again. The intensity of the regurgitation (once or hours long) should be considered.

Code 0 = No regurgitation.

Code 1 = Rarely regurgitation (up to once per month).

Code 2 = Sometimes regurgitation (up to once a week).

Code 3 = Frequent regurgitation (up to once a day).

Code 4 = Very frequent regurgitation (more than once a day).

16. Body Image Disturbances

DSM IV-AN-C1: Disturbance in the way which one's body weight or shape is experienced
IR-AN-C1: Self-perception of being too fat, with an intensive dread of fatness.
IR-BN-D1: A self-perception of being too fat, with an intensive dread of fatness.

Probes: According to your own standards, have you found your figure and body parts (thighs, waist) to be too fat, too thin, or just right?
Additional probes: Did you see yourself as fatter than other people saw you (such as physicians or nurses)? How discrepant was your image of your body compared to others' images of your body? Were you satisfied with your figure at your lowest weight?

Definition: This symptom, which was described by Hilde Bruch in 1973, requires a very skillful questioning technique. Usually, there is an overestimation of body proportions, especially of the thighs, hips and stomach. It is important to ask the patient how he or she sees the own body according to own standards. Be careful not to elicit socially desired responses. Some patients tend to express the opinion of others and not his own. Some patients deny body image disturbances (and fears of gaining weight); the interviewer may actually ask the patient to point with her fingers in the air how wide her hips, thighs etc. are (and compare it with the true width) or may ask how wide these body parts would be (or feel) if the person gained 5 kg.

Code 0 = No body image disturbance.

Code 1 = Slight body image disturbance: There is a slight discrepancy between how the patient sees him- or herself and how others see the person in the predicted direction (overestimation). There can be an emphasis on a single "body problem area" or a partial fixation on a certain problem area, which is only temporary.) If the person has set a weight limit it is not far from the normal or realistic weight. An overweight person may notice his or her weight gain with some latency and therefore show body image disturbances.

Code 2 = Marked body image disturbance: There is a marked discrepancy between how the patient sees herself and how others see the person. This perceptional distortion of feeling too fat applies to two or more problem areas. If the person has an individual weight limit, it generally corresponds to a realistic weight. Alternatively a person of ideal or normal weight may temporarly feel too fat at times of pressure and distress. Another example would be an obese person, who feels thinner as others see him or her, and who is shocked over her own body dimensions when confronted with "evidence" such as a video tape feedback.

Code 3 = Severe body image disturbance: There is a strong discrepancy between how the patient sees himself and how others see him. The perceptional distortion of feeling too fat applies persistently to the whole figure and can not be corrected.

> Example: a) Persons with normal or ideal weight, who constantly see themselves as too fat. b) Anorectic persons, who see themselves as being just right despite underweight. If there are subjective weight limits, they are markedly under the ideal weight.

Code 4 = Very severe body image disturbance: There is a very strong discrepancy between how the person sees him- or herself and how others see the person. The perceptional distortion of feeling too fat applies to many body parts or the whole figure, is constantly present, and is quite extreme.

Example: An anorectic person, who feels too fat, despite being marked underweight. If the person has a subjective weight limitation which may not be exceeded, it is far below the ideal weight.

17. For underweight patients only (underweight means that the person is below the weight which from all evidence can be extrapolied for the person):

Denial of threat to health caused by underweight

DSM IV-AN-C3: ... denial of the seriousness of the current low body weight (in AN)
If subject has never been underweight, code this item as 8.

Probes: If the person was underweight: **Did you think your low weight had negative consequences for your health?**
Additional probes: Have you experienced any medical complications of your underweight? Did you believe it could be dangerous to be at such a low weight?
Interviewer: Please rate the **discrepancy** between the objective dangers concerning the consequences of low weight and the opinion of the patient.

Definition: An underweight person who for him- or herself denies possible medical consequences of low body weight.

Code 0 = No: The person recognizes the negative consequences of being underweight and really wants professional help to gain weight. He or she has already taken concrete steps in this direction.

Code 1 = Slight: The person has some but limited recognition about negative consequences of being underweight and wants professional help to gain weight. No concrete steps have been undertaken or they have been postponed.

Code 2 = Marked: The person may or may not be generally aware of possible negative consequences of being underweight; for him- or herself no negative consequences of underweight can be seen by the person.

Code 3 = Severe: The person knows she is underweight, but insists there is no threat to her health.

Code 4 = Very severe: Low body weight and very severe denial of any negative consequences of being underweight.

Code 8 = Not/never underweight.

18. Only in women: Menstruation

DSM IV-AN-D: In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following homone, e.g. estrogen, administration.)

IR-AN-D: A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis is manifest in women as amenorrhea ....

Probes: How old were you , when you first menstruated?

19. Probes: How was your period in the last 3 months and how was it in past years?

This item is of course only to be evaluated for females. It is an important item, as it is a necessary requirement for the diagnosis anorexia nervosa by most standards. Patients are often treated with hormones, so that the menstrual cycle cannot be evaluated correctly - in this case code with "2" (= period only occurs with hormone preparations but when stopped irregularities occur) or "7" (= person has taken the pill for quite some time and therefore it is unknown whether the period would come or not). Score the lowest level of functioning for the three months before the interview and for the time since (post)-puberty when normal periods should have occured.

Code 0 = Normal and regular

Code 1 = Period occurred without hormone preparations but was fairly irregular or showed spotting

Code 2 = It is quite definite that periods occur only following hormone, e.g. estrogen administration (no period occurs when taking pill is stopped)

Code 3 = Secondary amenorrhoea (period didn't occur for at least three months)

Code 4 = Secondary amenorrhoea (period didn't occur for at least six months)

Code 5 = Primary amenorrhoea (period never came)

Code 6 = No period because of pregnancy

Code 7 = Takes the „pill". It is unknown whether the period would occur without hormone preparation.

Code 8 = Does not apply (i.e. male, hysterectomy)

20. If secondary amenorrhoea was present: How old were you when your period didn't occur for three months or more for the first time?

21. Binging

Probes: Did you ever experience episodes of binge eating during which you ate a large amount of food in a relatively short period of time (in general less than two hours).
Additional probes: How often did you experience such episodes? Describe such a binge attack. How much did you eat during these binges (how many calories per binge)? Did you feel exhausted afterwards?

Episodes of binge eating are those, in which large amounts of food are eaten in a relatively short period of time (usually less than two hours). This behavior may lead to financial problems or cause conflicts within the family or partner when the patients eat everything he or she can get. A tendency to deny binges may be present. If the interviewer does not know the person a stepwise approach may be helpful: The person should be first asked if he or she has ever had a fear losing control over eating and when this is answered affirmatively proceed to ask if the person has actually lost control over eating and if binge eating occured.

The degree of binge eating is to be evaluated:

a) <u>Objectively</u>: A binge according to DSM-IV is defined as eating in a discrete period of of time (e.g. within any two-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances. (In addition, the sense of lack of control over eating during the episode is of importance but it is rated separately in item 26.) In describing the scores of this item a caloric range is mentioned: for score 2 caloric intake ranging from 1000 to 3000 calories, for score 3 > 3000 to 5000 calories and for score 4 > 5000 calories. However, these are only rough guidelines for the interviewer, which must not be taken literally. The interviewer should rate this item taking circumstances and context into acount. The interviewer should have the patient describe a typical eating binge. Because there may be a tendency to deny, ask detailed and specific questions and be persistent. An eating binge, which would fullfil the criteria of DSM-IV should be rated with at least "2". According to DSM-IV an episode of binge eating is characterized by both of the following: 1. eating in a discrete period of time a relatively large amount of food and 2. a sense of lack of control over eating during the episode. The amount eaten and the sense of lack of control are seen as separate dimensions, which are rated separately in this item and in item 26 respectively.

b) <u>Subjectively</u>: To distinguish an eating binge from a normal or large meal, a certain sense of lack of control should be present. Eating behavior should be somewhat independent of a normal feeling of satiety.

In this item it is important that the person describes his or her eating behavior as well as the amount of food eaten in as much detail as possible, in order to objectively evaluate the amount eaten and the circumstances of eating. There is often a considerable discrepancy between the subjective evaluation and the objective severity of the eating binge. Some persons tend to "dramatize" (half a bar of chocolate means having a severe eating binge to them), while others tend to underestimate ("It's not as bad as it was"), and by further questioning it may become clear that an eating binge is now "only" 10,000 instead of the former 15,000 calories). Overweight persons tend to strongly underestimate their binges or may have "atypical" binges (see item 18.c) ("I'm on a diet the whole time, I hardly eat anything!", and estimate amounts of food as normal, which a normal weight person would judge to be excessive).

21.a Objective Criteria of Eating Binges

DSM IV-BN-A1 ... eating in a discrete period of time (e.g., within any 2-hour period) an amount of food, that is
DSM IV-BED-A1 definitely larger than most people would eat during a similar period of time and under similar circumstances.

IR-BN-A1: Recurrent episodes of overeating (at least twice a week over a period of 3 months) in which large amounts of food are consumed in short periods of time.

<u>Definition:</u> Binging means eating in a discrete period of time (e.g. within any 2-hour period) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

<u>Code 0</u> = No eating binges.

<u>Code 1</u> = Slight (objective) eating binges: There are some signs for binging but diagnostic criterion for eating an unusually large amount of food in a short period of time is not met. The amount of food eaten in a discrete period of time is only slightly larger than most people would eat during a similar period of time under similar circumstances. Eating less than 1000 calories during an episode can be used as a rough guideline only.

Code 2 = Marked (objective) eating binges: The amount of food eaten in a discrete period of time is clearly larger than most people would eat during a similar period of time and under similar circumstances. A caloric intake during the episode between 1000 and 3000 calories can serve as rough guideline for marking this code.

Code 3 = Severe (objective) eating binges: The amount of food eaten in a discrete period of time is considerably larger than what most people would eat during a similar period of time and under similar circumstances. A caloric intake of > 3000 to 5000 calories can serve as a rough guideline, but time and circumstances must be taken into account.

Code 4 = The amount of food eaten in a discrete period of time is much, much larger than what most people would eat during a similar period of time and under similar circumstances. Consuming more than 5000 calories can be taken as a rough guideline but time and circumstances must be taken into account.

21.b Subjective Rating of Eating Binges Based on the Opinion of the Person Interviewed

The person should be directly asked if he or she experienced binges and if yes how frequent and severe - to be rated on a scale from 0 = no to 4 = very severe and/or frequent.

Code 0 = No eating binge.

Code 1 = Subjectively slight binges.

Code 2 = Subjectively marked binges.

Code 3 = Subjectively severe binges.

Code 4 = Subjectively very severe binges.

22. Course of Binge Eating over Time

Probe: How could the course of your binge eating over time (months and years) best be described?

Definition: This item is meant to assess the course of binge eating over time globally. It is not the intention of this item to assess minor variations of the severity of binge eating over time. Many different variations of the course over time are possible. For those persons who ever had binge eating four major types of course of binge eating over time are distinguished. These four types differ in the percentage of time when binges occurred:

Code 0 = no binges.

Code 1 = short episodes of binge eating followed by longer intervals without binge eating. Overall bingeing occurred up to 30% of time (or less).

Code 2 = periods of binge eating and periods without of approximately equal length. Overall binge eating was present about 30-60% of the time.

Code 3 = long periods of bingeing with only short intervals without episodes of bingeing. Roughly, bingeing was present in 60-90% of the time.

Code 4 = chronic bingeing, almost no intervals without bingeing. Binge eating was present chronically throughout the time, roughly 90-100%. There were no major intervals without marked binge eating.

For the lifetime assessment the period taken into account is the time from age 15 to the timepoint three months before the present assessment. The time period relevant for „current“ refers to the three months preceding the present interview. If bingeing was present at least once or twice weekly for 50% of the weeks in the relevant time period, this would mean that „bingeing was present in 50% of the time“.

23. Average Frequency of Binge Eating

DSM IV-BN-C1: Binge eating (and inappropriate compensatory behaviors both) occur on the average at least twice a week for at least three months.

IR-BN-A2: Binge eating episodes at least twice a week for any three-month period.

Probe: How often did you have marked eating binges over a period of three months?

Definiton: This item estimates only the frequency of objective eating binges. Intensive questioning may be necessary when denial is present (because of shame, guilt etc.). Phases in which eating binges occured more frequently are to be compared with phases in which it occured less frequently and an average should be calculated.

Code 0 = No eating binges.

Code 1 = Seldom: In a period of three to six months there are an average of two eating binges a week.

Code 2 = Occasionally: In a period of three to six months there is an average of less than two eating binges a week.

Code 3 = Frequent: Eating binges occur on the average up to once daily in a period of three to six months.

Code 4 = Very frequent: Eating binges occur more than once daily.

Code 5 = At least twice a week, but for less than 3 months.

24. Frequency of Marked Eating Binges Over a Period of 6 Months

DSM IV-BED-D1: Eating binges, on the average,... for at least six months

Coding analogous to item 23.

25. Eating Binges Usually Occuring on at least two different days in a week

DSM IV-BED-D2: Eating binges, on the average of at least two days in a week for a period of six months

Code 0 = no

Code 1 = yes

Code 8 = no eating binges

26. Sense of Lack of Control Over Eating

DSM IV-BN-A2 ...sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop
DSM IV-BED-A2 eating or control what or how much one is eating)

Probes: Did you experience a sense of lack of control over your eating behaviour during the binges? To what degree? Did you have the feeling you could not stop eating during an episode and control what or how much you were eating?
Additional probes: For example, would it have been very difficult or even impossible to answer the phone or the doorbell in the middle of a binge?
Interviewer: Only if obviously severe, ask whether they have been so desperate for food that they have stolen it in order to binge or taken food from waste receptacles.

Definition: This item measures the sense of lack of control over eating during an episode of eating. It assesses the feeling that one cannot stop eating or control what or how much one is eating. What is rated here is the subjective fear of the person to lose control over eating. The actual ability to stop a binge may give some indication about the fear to lose control. A further indicator for loss of control is when a person avoids eating in certain places where she knows she could be disturbed while eating. Can the person stop before starting a binge or during a binge by him-/herself? Can he or she stop a binge only on being disturbed by something external (telephone ringing, other person appearing in room) or when he or she is feeling abdominal pain or fullness? The amount of food eaten in a certain period of time (item 21) and the sense of lack of control over eating during the episode of eating are rated separately and independently.

Code 0 = No loss of control over eating.

Code 1 = Slight loss of control over eating: Subjective feeling of satiety is frequently exceeded during regular meals or binges. The person continues eating, although already satiated. The consequence is a feeling of being quite full.
Alternative: A person standing in front of the refrigerator gets into a conflict between wanting to eat on the one hand and forbidding herself to eat on the other hand; she finally ends up eating (usually with feelings of guilt). After disruptions through external stimuli the person can generally stop eating.

Code 2 = Marked loss of control over eating: The urge to eat or binge can be controlled to the extent that the person only eats at planned or specified times or can, if necessary, delay it temporarily. The person makes sure that others do not notice his or her binge eating. Foods are not indiscriminately eaten, but are usually chosen according to how easily they can be vomited. Eating can be stopped after a subjective time limit, in order to guarantee that the food can be gotten rid of before it is digested (the type and amount of food eaten during an eating binge are somewhat controlled). The eating binge itself is ended before stomach aches result. An interruption of the binge eating through external stimuli is only partially possible and is dependent on the intensity of the stimulus and the situational context. For example the telephone can usually be ignored, while the doorbell is still answered, if the person believes others must know that he/she is at home.

Code 3 = Severe loss of control over eating: The urge to eat must be immediately satisfied, but the person has sufficient control over him- or herself that he/she does not begin to eat in public. Also precautions are taken that nobody may notice their binge eating. The person eats anything that is available almost without choosing the amount or type of food. There is, however, some rest of control: Trashcans are not emptied nor is food stolen in order to binge immediately. External stimuli do no longer interrupt the binge eating. The binge is usually ended by physical circumstances such as stomach aches or falling asleep.

Code 4 = Very severe loss of control over eating: Person is extremely afraid of losing control. The urge to eat must immediately be satisfied under all circumstances, so that there are usually no inhibitions whatsoever. Frequently the eating takes place in public, sometimes even trashcans and waste paper baskets are emptied in a search for something to eat or food is stolen for an immediate binge, when the person has no more money. External stimuli (telephone, doorbell) cannot help to interrupt the binge. The eating continues as long as there is still food available; stomach pains or nausea are no longer noticed. The eating binge is ended only when there is no more food or no more space in the stomach. In this case vomiting may be induced in order to continue eating.

If eating binges occured:

27. Characteristics of Eating Binges

DSM IV-BED-B: Binge eating is associated with three or more of the 5 statements listed in this item in the interview.

Probes: When binge eating do you eat faster than normal?

Did you eat during binges until you feel uncomfortably full?

Did you eat large amounts of food when you were not feeling physically hungry?

Did you eat alone during a binge, because of being embarrassed by how much you ate?

Did you feel disgusted with yourself or very guilty after overeating?

28. Feelings of Distress Regarding Binge Eating

DSM IV-BED-C: Marked distress regarding binge eating is/was present

Probe: Have you experienced distress regarding binge eating?

Additional probes: Did you feel worried or even desperate about the binges? Are they a problem for you? Did you feel worried or even desperate because of the struggle to stop binge eating? Were you concerned about not being able to control or stop the binging? Were you concerned about the weight you would gain because of the binging? Or what the binging would do to your body?

Definition: This item should be rated according to the degree to which the patient is emotionally distressed about having eating binges. The marked distress regarding binge eating usually has to do either with a) the experience of losing control during the binge, or b) worrying about the amount of food eaten during a binge (anxiety about what they are doing to their body or about gaining weight due to the binge. (The latter is also rated under the item: fear of gaining weight).

Code 0 = No distress.

Code 1 = Slight distress: The person thinks occasionally about the eating binges and their consequences and may feel a slight uneasiness but they do not feel really distressed.

Code 2 = Marked distress: The person frequently worries about the eating binges and their consequences and shows marked distress.

Code 3 = The binges and their consequences present a severe problem for the person, and cause severe distress.

Code 4 = The person feels desperate and distressed in regard to eating binges and their consequences. He or she feel very abnormal, may have thoughts about being insane or may feel panic about possible weight gain.

29. Atypical Eating Binges

Probes: Did you eat the whole day long or during part of the day (e.g. in the evening) without planning meals? (Some people refer to this eating pattern as grazing.)
Additional probes: If so, how much did you eat?
Interviewer: Please rate on the basis of all evidence available.

Definition: Besides the eating binges described in item 21 there are further variants, which are particularly prevalent in obese persons. The main charateristic of these binges is that food is actually not binged in a short period of time but rather ingested more or less continuously throughout the day. To be considered here are also the "constant overeaters":

These persons report that they constantly eat during the whole day, which means that they constantly snack between regular meals. The amounts of food consumed are small, so that it does not constitute an eating binge in the strict sense of the word. There is only a slight loss of control. Sometimes people may refer to this behavior as „grazing“.

Examples:

a) "sustained" overeating with a lack or only a slight loss of control: The person reports enjoying eating large amounts of food over a long period of time. Often, the whole evening is spent cooking and eating. The food is of central importance ("I eat until I feel uncomfortably full and nothing more can be eaten."). The feeling of losing control or having a sudden binge as in a classical eating binge is lacking in these cases.

b) "problem eating binges" with little or no loss of control: The person reports that he or she begins to eat when there are problems or tensions. Eating increases when under stress. Large amounts of food may be consumed, but without the suddenness or the loss of control characteristic of a classical eating binge.

If a person has no atypical binges the rating is "0".

If there are binges as described in item 21 (typical) and 29 (atypical), both should be rated independently.

Item 26 (loss of control) is rated for typical binges only (item 21) and not for "atypical binges" (29).

Severity rating is analogous to the objective binge attacks (item 21). Calorie counts refer only to food consumed in addition to the daily caloric need.

Code 0 = No atypical binges.

Code 1 = Slight atypical binges. Calorie count is below 1000 kcal.

Code 2 = Marked atypical binges. Between 1000 and 3000 calories are consumed.

Code 3 = Severe atypical binges. Between 3000 and 5000 calories are consumed.

Code 4 = Very severe atypical binges. More than 5000 calories are consumed.

30. Probe: Did you feel comfortably full after eating large amounts of food for hours?

Ratings from 0 = neither nor to 4 = very strongly comfortable and from 5 = slightly uncomfortable to 7 = strongly uncomfortable.

31. Average number of marked atypical eating binges

Probe: How often have you had atypical eating binges in a period of 3 months?

Definition: The frequency of typical eating binges have been rated in item 23. In this item 31 only frequency of binges should be rated; if typical and atypical binges have both been present, each should be coded independently from one another.

Ratings are made on a scale from 0 = Never, 1 = Rarely (Less than twice a week on average), 2 = Sometimes (At least twice weekly on average), 3 = Frequently (Up to once daily), 4 = Very frequently (More than once daily).

32. Average Frequency of Atypical Eating Binges in a period of 6 months

Probe: How often have you had atypical eating binges (grazing) in a period of 6 months?

Definition: The frequency of typical eating binges have been rated in item 23. In this item 31 only frequency of binges should be rated; if typical and atypical binges have both been present, each should be coded independently from one another.

Ratings are made on a scale from 0 = Never, 1 = Rarely (Less than twice a week on average), 2 = Sometimes (At least twice weekly on average), 3 = Frequently (Up to once daily), 4 = Very frequently (More than once daily).

33. Probe: Did you eat more than usual when you felt stressed or overburdened?

Ratings from 0 = no to 4 = very strongly.

34. Craving for Food
IR-BN-B2: ... strong desire or compulsion to eat (craving)

Probe: Have you experienced a strong desire or compulsion to eat, and did you crave food which you generally avoid (e.g. chocolate, spaghetti)?
Additional probes: How often? If you tried to resist these urges, how uncomfortable did you feel?

Definition: By craving is meant the urge to binge. In principle a person may have very strong urges to binge (craving) but behaviorally may never have binged.

Code 0 = No craving for or compulsion to eat food which is normally avoided.

Code 1 = A slight feeling of discomfort arises when the compulsion to eat is resisted, or craving for food is seldom present.

Code 2 = A marked feeling of discomfort arises if the compulsion to eat is resisted, or craving for food occurs sometimes (twice a week) but not frequently.

Code 3 = Distraction is hardly possible, and the compulsion to eat can hardly be resisted, or the compulsion occurs frequently (about once a day).

Code 4 = The compulsion to eat (craving) is a major theme of everyday life (very severe), or it occurs very frequently (several times a day).

35. - 44. Inappropriate Compensatory Behaviors in Order to Prevent Weight Gain

Definition: One or more inappropriate compensatory measures to counteract gaining weight are used in order to control body weight.

Code 0 = No inappropriate compensatory behaviors to counteract weight gain are used.

Code 1 = An inappropriate compensatory behavior is used only rarely (less than twice a week); when drugs are used: non-prescription drugs are used more frequently than recommended.

> Example: The patient took an appetite suppressant drug which she bought herself over the counter without needing a prescription. She used it infrequently. In addition, when she visited her mother she took some of her mother's diuretics (about two days a month).

Code 2 = An inappropriate compensatory behavior to counteract weight gain is occasionally used by a person in order to reduce body weight (at least twice a week) or a drug is used considerably longer than prescribed or in higher dosage and may be obtained from different sources.

> Example: The person's friend, who worked as a receptionist in a doctor's office gave her a prescription for a diuretic for three months (same dosage as prescribed by the physician).

Code 3 = High dosage or frequent use of an inappropriate measure to counteract weight gain. When drugs are used the person frequently gets it without prescription. The person gets tense if the drug is not available.

Code 4 = Very high dosage or a very frequent use of an inappropriate measure to counteract weight gain. When drugs are used strong anxieties arise if the medication is not available.

> Example: A person had taken about 50 pills of a prescription drug laxative containing bisacodyl and senna. It was inconceivable to stop taking pills for a period of 24 hours. Nevertheless, the person was worried about possible damage to health due to side effects of the medication. The shape of her fingernails had changed over the 8 years she had taken it (drum-stick fingers) as a sign of hypertrophic asteoarthropathia resulting from chronic laxative intoxication.

35. Vomiting

DSM IV-BN-B1: Recurrent inappropriate compensatory behavior such as vomiting in order to prevent weight gain.

IR-BN-C1: Counteracting the "fattening" effects of food by self-induced vomiting

Probes: Did you induce vomiting? Did you do so in order to avoid weight gain, or in order to feel relieved? Did you vomit mainly after binging? How often and in what way did you induce vomiting?

Definition: Phases during which the patient vomits frequently are to be compared with those phases during which the patient vomits rarely or does not vomit at all and an average for a limited period of time (3 months with relatively high frequency) in the past or for the last three months should be established. Cases in which the patient reports vomiting "automatically" without having to actively induce it (= conditioned vomiting) are also counted as intentional self-induced vomiting (unless there is a clinically prooven organic cause, such as a pyloric stenosis). It is recommended that this item is closely focused upon: First ask if a feeling of being very full is present after meals and if the discomfort was so strong that the patient felt like vomiting. Because there may be a tendency to deny the symptoms additional information should be taken into account such as the reaction of the patient to the questions and (if available) additional information from other persons (family members, nurses etc.) should also be used when rating this item.

Code 0 = No vomiting.

Code 1 = Vomiting rarely: The person vomits on the average less than twice a week.

Code 2 = Vomiting occasionally: The person vomits on the average at least twice a week.

Code 3 = Vomiting frequently: The person vomits about once a day.

Code 4 = Vomiting very frequently: The person vomits several times a day.

36. Laxative abuse
DSM IV-BN-B2: Laxative abuse as inappropriate compensatory behavior in order to prevent weight gain
IR-BN-C2: Laxative abuse to counteract "fattening" effects of food

Probe: Did you ever use laxatives to avoid gaining weight?
Additional probe: Which laxatives did you use and in what amount? How often? And for what period of time? How would you feel if you had to stop using laxatives?

Definition: The reasons why laxatives are taken are to treat or prevent constipation; eating disordered patients take laxatives frequently with the idea that food ingested (calories) will be absorbed less while in the gastro-intestinal tract if the passage is faster. Laxatives can have addicting properties and some persons tend to increase the dosage (see case example above). Some patients report that they felt fresh and cleaned inside when their body had reacted to the laxative taken; this feeling can be so positive that gastro-intestinal cramps are taken into account. Please rate the severity of laxative abuse on the basis of the frequency a laxative is taken and the dosage used. For the rating it makes no difference how the laxative was obtained (faking doctor's prescriptions), although such information may be valuable for judging the degree to which a person may be addicted to taking laxatives. Quite a few patients take laxatives secretly and may deny laxative use or abuse. As in other forms of abuse or dependency a stepwise approach in exploring the issue should be used: Has the person had constipation, if so, what has he or she done about it? What kind of laxatives were used? In what dosage? Were there times when this dosage was not sufficient? What was the highest dosage the person has ever taken? If available, information from other persons (e.g. family members, nurses) should also be used for rating this item.

Code 0 = No laxative abuse.

Code 1 = Laxative use rarely (less than twice a week) and/or in low dose: One or two pills are taken in rare cases (for example on vacation), but there is no habitual use. Phases of constipation can be tolerated without immediately taking a laxative. The dose the person takes corresponds to the recommended dose.
Alternative: Occasional or frequent drinking of laxative teas or eating of dried fruits (prunes) in normal amount.

Code 2 = Laxative abuse sometimes (at least twice a week) and/or in moderate dose: Weekly use in low to moderate dose or seldom (maximum once a month) high dose. When laxatives are not available marked discomfort or tension arises.
Alternative: Daily drinking of laxative teas in high dose or eating dried fuits (prunes) in excessive amounts in order to purge (for example a pack a day).

Code 3 = Laxative abuse frequently (up to once daily) and/or high dose: Daily use in low to moderate dose or occasionally (up to once a week) high dose. When laxatives are not available very severe discomfort or tension arises.

Code 4 = Laxative abuse very frequently (several times a day) and/or very high dose: A moderate dose is taken regularly and frequently (several times a day) or a very high dosis (e.g. 10 - 50 pills containing bisacodyl or senna) is used daily. It is inconceivable for the person to stop taking laxatives.

37. Use of Diuretics (Dehydration Pills) as an Inappropriate Compensatory Behavior in Order to Counteract Weight Gain
DSM IV-BN-B3: Use of diuretics as inappropriate compensatory behavior in order to counteract weight gain
IR-BN-C4c: Use of diuretics to counteract "fattening" effects of food
Additional probes: Which ones? How often? For what period of time? How would you have felt if you had to stop using them?

Definition: Diuretic drugs are used by some eating disordered patients to lose weight quickly irrespective of the fact that it is water and not fat that is lost. Some persons may take diuretics in an attempt to counteract not only possible weight gain but also for "cosmetic" reasons, believing that it has positive effects on their skin. Ratings are made on the basis of the frequency of which diuretics are used and the dosage. Information on how the pills were obtained may be informative of possible abuse, but does not enter the rating directly.

In this item the use of diuretics is rated only if it occurs as an inappropriate compensatory behavior in order to counteract weight gain. If a patient must take a diuretic medication for medical reasons (e.g. heart insufficiency) this is not rated as abuse and may be coded as "0". If both, medical condition such as insufficiency of the heart and an eating disorder with laxative abuse coincide, the abuse component is rated in the item.

Code 0 = No abuse of diuretics.

Code 1 = Rare abuse (less than twice a week) and/or low dose: The person takes a normal dosage every now and then, but there is no habitual use of diuretics.

Code 2 = Sometimes (at least twice a week) and/or moderate dose: Weekly use in low to moderate dosage (up to four pills) or a high dose (five to ten pills) used rarely (up to once a month). Not taking the diuretics leads to clear discomfort or tension.

Code 3 = Frequent use (up to once daily) and/or high dose: Daily use in low to moderate dosage (up to four pills) or occasional use (up to once a week) in high dosage (five to ten pills). Not taking the diuretics leads to severe discomfort or tension.

Code 4 = Very frequent use (several times a day) and/or very high dosage: At least one or two pills are taken several times a day on regular basis or once a day a very high dosage is taken on a regular basis. It is inconceivable for the person to stop taking a diuretic.

38. Appetite suppressants
DSM IV-BN-B4: Use of appetite suppressants as inappropriate compensatory behavior to counteract "fattening" effects of food
IR-BN-C4a: Use of appetite suppressants as inappropriate compensatory behavior to counteract "fattening" effects of food

Additional probes: Which ones? How often? For what period of time? How would you have felt if you had to stop using them?

Definition: The rating is based on the frequency with which appetite suppressants are taken and on the dosage. The fact whether the appetite suppressant has been prescribed by a physician or has been obtained through other more obscure ways may give hands to the abuse and dependency component but should not enter the ratings directly.

Code 0 = No abuse of appetite suppressants.

Code 1 = Rare use (less than twice a week) and/or low dosage: Mild appetite suppressants are taken infrequently, but there is no habitual use or abuse. The dose taken is moderate.

Code 2 = Abuse sometimes (at least twice a week) and/or marked dosage: At least weekly use in low to moderate dosage or occasional use (up to once a week) in a higher dosage. Stopping to take the appetite suppressant leads to marked discomfort or tension.

Code 3 = Frequent use or abuse of appetite suppressant (up to once daily) and/or higher dosage: Daily use in low to moderate dosage or occasional use (up to once a week) in high dosage. Stopping to take the appetite suppressant leads to considerable discomfort or tension.

Code 4 = Very frequent use or abuse (several times a day) and/or taking it in very high dosage: A considerable dosage is taken several times a day or a very high dose is taken once a day on a regular basis. Discontinuing the appetite suppressant leads to severe discomfort or tension or is inconceivable by the person.

39. Medication to increase thyroid metabolism

DSM IV-BN-B4: Use of medication to increase thyroid medication as inappropriate compensatory behavior to counteract "fattening" effects of food

IR-BN-C4b: Use of medication to increase thyroid medication as inappropriate compensatory behavior to counteract "fattening" effects of food

Definition: The rating is based on the frequency of taking a medication to increase thyroid metabolism as well as the dosage. Both, frequency and dosage must be taken into account! This item refers to deliberately taking medication to increase thyroid metabolism as an inappropriate compensatory behavior to counteract "fattening" effects of food. If medication to increase thyroid metabolism is taken not for this reason but for purely medical reasons (hypothyroidism) this should be rated as "no abuse" = code "0".

Code 0 = No abuse of thyroid medication.

Code 1 = Abuse of thyroid medication rarely (less than twice a week) and/or in low dosage: A low dosage is rarely taken, but there is no habitual use.

Code 2= Abuse of thyroid medication sometimes (at least twice a week) and/or in moderate dosage: Weekly use in low to moderate dosage or a high dose is taken rarely (up to once a month). Discontinuation of the medication leads to clear discomfort or tension.

Code 3 = Abuse of thyroid medication frequently (up to once daily) and/or in high dosage: Daily use in low to marked dosage or occasional use (up to once a week) in a high dosage. Stopping to take the medication leads to marked discomfort or tension.

Code 4 = Very frequent abuse of thyroid medication (several times a day) and/or very high dosage: A marked dosage is taken very frequently (several times a day) or a very high dosage is taken regularly (about once daily). Discontinuation of the medication leads to severe discomfort or tension or it is inconceivable to the person.

40. For Diabetics: Neglect of (insulin) medication

DSM IV-BN-B8: Neglect of insulin medication as inappropriate compensatory behavior to counteract effects of "fattening" food

IR-BN-C4d: Neglect of insulin medication as inappropriate compensatory behavior to counteract effects of "fattening" food

Probe: Did you neglect insulin treatment in order to avoid weight gain?

Neglect of insulin medication as an inappropriate compensatory behavior to counteract effects of "fattening" food is rated on the basis of the frequency that this happens and the dosage skipped and thus the overall medical severity of neglect of insulin medication as an inappropriate compensatory behavior to counteract effects of "fattening" food.

Ratings are made as usual in the SIAB from 0 (no neglect) to 4 (very frequent or very severe neglect of insulin medication as an inappropriate compensatory behavior to counteract effects of "fattening" food).

41. Excessive Fasting
DSM IV-BN-B5: Excessive fasting as inappropriate compensatory behavior to counteract the "fattening" effects of food
IR-BN-C3: Excessive fasting as inappropriate compensatory behavior to counteract the "fattening" effects of food

Probe: Did you refrain from eating anything for more than 24 hours in order to avoid weight gain?

Definition: Excessive fasting is defined as restraining from eating anything for more than 24 hours in order to counteract "fattening" effects of food. Fasting is defined as restraining from eating anything. Previous items on quantitative and qualitative food reduction (item 11) primarily but not exclusively focus on the dieting behavior. The present item focuses on complete food abstinence for more than 24 hours. It is rated how frequently this is done and to what extent (over what period of time). Excessive fasting requires that the behavior is intentional and constitutes an inappropriate compensatory behavior to counteract the "fattening" effects of food. If a person is starving for more than 24 hours because no food is available this does not qualify as "excessive fasting". The frequency of eating nothing at all for more than 24 hours and the severity of fasting (number of successive days of eating nothing) both enter the rating of "excessive fasting".
If subjects report no food intake but the drinking of nutritive substances like milk, protein shakes, or dietary supplements, count this as fasting if the caloric value is less than 400 calories per day.

Code 0 = No excessive fasting-

Code 1 = Excessive fasting rarely and/or slightly: The person rarely fasts for more than 24 hours. This should not occur more than once a month.

Code 2 = Excessive fasting occasionally and/or markedly: The person fasts once a week or fasts for several days (up to three in a row) and is thereafter eating more or less normally.

Code 3 = Excessive fasting frequently and/or severely: The person has fasted more than once up to seven days. Alternatively the person has eaten nothing for a period of up to ten days once.

Code 4 = Excessive fasting very frequently and/or severely: The person has fasted several times (longer than a week) or has eaten nothing at all once for two weeks or more.

42. Excessive Exercise
DSM IV-BN-B6: Excessive exercise as inappropriate compensatory behavior to counteract the "fattening" effects of food
Probes: How much exercise did you engage in? If you couldn't exercise, did you feel uneasy or stressed?
Additional probes: Did you find it difficult to sit still over long periods of time? What types of exercise did you engage in? How often? For how many hours a day? Have there been times when you declined opportunities to be with friends in order to exercise? Have you ever

exercised despite an injury or illness that would have prevented others from exercising? Have you engaged in sports or exercised to burn up calories and to toughen and trim your body?

Definition: In this item frequency and intensitiy of excessive exercise as an inappropriate compensatory behavior to counteract the "fattening" effects of food are rated. The motivation of a person exercising excessively is to "burn calories". Excessive exercise may have addicting properties and a patient may tend to deny that the amount of exercise done is excessive. Excessive exercise means doing more physical activity in the exercise than may in the long run be physically healthy. When information on excessive exercise is also obtainable from persons knowing the subject well this can be quite helpful. Inner restlessness or nervousness and problems in sitting still are not counted in rating this item, which focusses on major motor activity as an inappropriate compensatory behavior to counteract the "fattening" effects of food.

Code 0 = No excessive exercise.

Code 1 = Excessive exercise slightly and/or rarely: A person rarely exercises (for example on weekends or in the evenings) in order to burn calories or to reduce weight, but can just as well turn to other activities, if they are interesting or appear more important.

Code 2 = Excessive exercise markedly and/or occasionally: A person exercises sometimes (up to twice weekly) or with marked vigor (example: "then I had my jogging-phase"). The person may report discomfort when prevented from exercising. Distraction is possible but is associated with some discomfort.

Code 3 = Excessive exercise strongly and/or frequently: The person objectively excercises very much (every day for more than one hour or three to four times a week two hours or more), and also experiences discomfort when prevented from exercising.

Code 4 = Excessive exercising very strongly and/or very frequently: Excessive exercise is done more than once a day or for longer periods (more than ond and a half hours per day). The exercises are done irrespective of physical weakness, leashence and pain as a consequence of excessive exercising.

> Example: A patient who jogged in the morning as well as in the evening for at least one hour. During the day she either swam or cycled for at least one hour. According to her orthopedic's report she had severe problems with her knees and sometimes her heels bleeded because of her excessive exercising, but she did not pay attention to this.

43. Enemas

DSM IV-BN-B7: Enemas as inappropriate compensatory behavior to counteract the "fattening" effects of food

Probe: Did you use enemas in order to avoid weight gain?

Definition: Frequency and intensity of using enemas as inappropriate compensatory behavior to counteract the "fattenting" effects of food are rated in this item on a scale from 0 = no enemas to 4 = very frequent (more than once a day).

44. Ipecac
DSM IV-BN-B1: inappropriate compensatory behavior to counteract the "fattening" effects of food

Probe: Have you ever used medication (such as ipecac) in order to induce vomiting?

45. Frequency of inappropriate compensatory behaviors to counteract weight gain
DSM IV-BN-C2: (Binge eating and) inappropriate compensatory behaviors to counteract weight gain occured on the average at least twice a week for 3 months.
D-EDNOS-3/D-EDNOS-4a

Probes: How often did you use measures to counteract weight gain such as self-induced vomiting, laxatives, dehydration medication, appetite suppres-sants, thyroid medication, extreme dieting, excessive exercising , enemas or ipecac?

> Example: Frequency of inappropriate behaviors to counteract weight gain over a period of three months according to DSM IV are met:
> A patient vomited (and continues to vomit) on the average three times a week for the last two years (!); in addition, she took diuretics about once a week for 4 months and laxatives at least twice weekly for one month.

This patient meets the criteria (answer "yes" = presence of inappropriate behaviors to counteract weight gain) for this item. According to the criteria at least one measure to counteract weight gain has to be used at least twice weekly over a period of three months (vomiting). Various measures can be added together here. Measures to counteract weight gain may also be present even if the patient does not vomit. For example a person who has binged but never vomited has used laxatives at least twice a week for two consecutive months and in the following month used appetite suppressants at least twice weekly to counteract weight gain meets the criteria.

46. Lowest weight when using inappropriate behaviors to counteract weight gain
DSM-IV-EDNOS4: The regular use of inappropriate compensatory behavior by in individual of normal body weight after eating small amounts of food.
Probe: What was your lowest body weight when you used measures to counteract weight gain like ...

Note: If marked binges occurred, the item is not applicable and coded as 8.

Code 0 = Normal weight (+/- 15%)

Code 1 = Obese (> 15% over normal body weight)

Code 2 = Underweight (> 15% below normal weight)

Code 8 = Does not apply (e.g. marked eating binges occured or no counterregulatory measures)

47. Type of measures to counteract weight gain
DSM IV-BN-Type of BN: Purging type vs. non-purging type

Definition: In this item the interviewer judges on the basis of the information obtained in the previous items what type of bulimia nervosa or other form of recurrent overeating is or was present in the person interviewed. Interviewer: Please do not bother to judge whether or not the other criteria for bulimia nervosa according to DSM IV are met. Consider only inappropriate compensatory behavior to counteract

the "fattening" effects of food assessed in the previous items. The type of measures to counteract weight gain is assessed irrespective whether the person had eating binges or not. A person who had eating binges (irrespective of severity and frequency) and used only dieting or fasting or excessive exercise to counteract weight gain is classified as "0" = non-purging type. A person with binges (irrespective of frequency and severity) or used either self-induced vomiting, abuse of laxatives, diuretics, appetite suppressants, thyroid medication, enemas or other similar equivalent methods regularly for a defined period of time is classified as "1" = purging type. A person who used no measure to counteract weight gain whatsoever is classified under the code "8".

Example: A person has counteracted weight gain by excessive exercise (five times a week) and takes laxatives twice weekly and has done so for at least three months. The person is classified as "purging type" because of the laxative abuse of defined frequency over a longer period of time.

Code 0 = Non-purging type: fasting, dieting and/or excessive exercise only (to counteract weight gain).

Code 1 = Purging type: vomiting, laxatives, diuretics, appetite suppressants, enemas, thyroid medication or equivalent measures to counteract weight gain. Fasting, dieting and/or excessive exercise may be used or not.

Code 2 = Irregular purging type: All criteria for bulimia nervosa met, purging behavior does not meet specific criterion.

Example: A patient shows twice a week for at least 3 months excessive fasting as compensatory behaviour and meets all criteria of bulimia nervosa. At the same time the patient vomits once a week.

Code 3 = Mixed type: at times purging behavior regularly used and at other times purging behavior not regularly shown. This type can be coded for the lifetime course of eating disorder.

Code 8 = Does not apply (no measures to counteract weight gain)

48. Simultaneous occurence of anorectic symptoms

Probes: You have reported that you had a low body weight, that you had an intense fear of gaining weight, that you (paraphrase: body image disturbances, dependence of self-esteem on figure and weight and/or denial of risks of low body weight) and that your period (paraphrase: never occurred, stopped, only occurred with hormone preparations). Has there ever been a time during which these symptoms occurred simultaneously? (If it is not clear, let the patient describe, how distinct the symptoms were.)

Definition: This item clarifies whether the different anorectic symptoms occurred simultaneously in the past. Ask only if all criteria of anorexia nervosa were fulfilled in the past. The items in the grey box are meant for a better control. Here you should sum up your previous findings. If not all criteria are fulfilled code 8 and go on to the next question.

If there is uncertainty concerning criterion A (body mass index below 17.6 for women and below 18.6 for men) consider this criterion as fulfilled for the present. Criterion D is considered fulfilled if menstruation did not occur although there is no pregnancy and if it is not known whether the period would occur without hormone preparation (item 19, code 6 or 7).

Code 0 = No

Code 1 = Yes

Code 8 = Does not apply (not all criteria of AN fulfilled)

If all criteria were fulfilled simultaneously ask the patient how old she/he was when this was the case for the first time.

Probes: How old were you when all symptoms occurred simultaneously for the first time? (If necessary, sum up: when you were underweight for the first time, had fear of gaining weight and (describe corresponding symptom of criterion c) and your period (did not occur, war irregular, only occurred with hormone preparations)).

49. For persons with probable diagnosis of AN: Specification of the type of anorexia nervosa
DSM IV-AN-Type of AN: Restricting Type vs. Binge Eating/Purging Type

Probes: During the anorectic phase (e.g. underweight, fear of gaining weight, denial of the seriousness of the low body weight) **did you binge-eat or use measures to counteract weight gain** such as self-induced vomiting, use of laxatives, diuretics or other medication?

Definition: This item has to be judged by the interviewer on the basis of the information obtained in the items above and if certain issues are known or open ask questions now. Rating is separately for binging (49.a) and purging behavior (49.b). According to DSM IV two types of anorexia nervosa are distinguished: 1. restricting type and 2. binge eating/purging type.

a) Example for AN restricting type: According to the information obtained in the interview a person probably meets criteria for anorexia nervosa; in order to reduce body weight the person has used fasting, dieting or excessive exercise but no "purging behavior" and has had no binge eating.

b) Example for binge eating/purging type of AN: A person is likely to meet the criteria for AN and has had binge eating and/or purging type behaviors as inappropriate compensatory behavior to counteract weight gain (self-induced vomiting, abuse of laxatives, diuretics, appetite suppressants, enemas or thyroid medication).

c) A person who has never in the past or present had anorexia nervosa is coded as "8" (item does not apply).

The anorectic episode has to constitute the complete picture of anorexia nervosa (Code = 1 in item 48). In lifetime both types of anorexia nervosa may have ocurred (= code 3). An episode should have a duration of at least 3 months.

50. Simultaneous occurrence of bulimic symptoms

Probes: You have reported that you had episodes of binge eating, loss of control over eating, that you used inappropriate compensatory behaviors such as ... and that your self-esteem was highly dependent on your body shape and weight. Has there ever been a time during which these symptoms occurred simultaneously? Did the binge eating and purging behavior occur 3 months or more at least twice a week simultaneously? (If it is not clear, let the patient describe, how distinct the symptoms were.)

Definition: This item clarifies whether the different symptoms of bulimia nervosa were fulfilled simultaneously in the past. Ask only if criteria A-D of BN were fulfilled in the past. The items in the grey box are meant for a better control. Here you should sum up your previous findings. If not all criteria are fulfilled code 8 and go on to the next question.

Code 0 = No

Code 1 = Yes

Code 8 = Does not apply (not all criteria of BN fulfilled)

If all criteria were fulfilled simultaneously ask the patient how old she/he was when this was the case for the first time.

Probes: How old were you when all symptoms occurred simultaneously for the first time? (If necessary, sum up: when you had binges and (corresponding counteracting measures) simultaneously for the first time and your self-esteem was highly dependent on your body shape and weight?)

51. For persons with binges (probable diagnosis of BN or BED): Simultaneous occurrence of anorectic and bulimic episodes

DSM IV-BN-E: Disturbance does not occur exclusively during episodes of AN.
DSM IV-BED-E1: Disturbance is not associated with regular use of inappropriate compensatory behaviors and does not occur exclusively during the course of AN or BN.

Probes: Were the bulimic symptoms (binges and possibly vomiting or laxative use) **only present in times during which you ate very little or tried to keep your weight as low as as possible?**

Definition: The interviewer should rate this item for all patients who had or have eating binges. Whether or not the criteria for BN or BED are met will later be determined using the computer algorithm. This item addresses the issue of whether criteria for anorexia nervosa according to DSM IV were met concurrently with a (probable) diagnosis of BN or BED. Interviewer: Focus on whether or not DSM IV criteria for anorexia nervosa were/are met concurrently to binge eating and probable diagnosis of BN or BED (which will later be verified by the analysis of the results, e.g. the computer algorithm).

Rating is separately for binging (51.a) and purging behavior (51.b).

Code 0 = No: Either never anorexia nervosa or bulimic episodes also in times during which at least one criterion of AN (e.g. underweight) was not fulfilled.

Code 1 = Yes: Bulimic episodes only in times during which all criteria of anorexia nervosa are fulfilled simultaneously.

Code 8 = Does not apply (no bulimic symptoms)

52. Simultaneous occurrence of Binge Eating Disorder (BED) symptoms

Probes: You have reported that you experienced binges and loss of control, that you (paraphrase: corresponding features of criterion B) and that you were worried or desperate about your binges. Has there ever been a time during which these symptoms occurred simultaneously? (If it is not clear, let the patient describe, how distinct the symptoms were.)

Definition: This item clarifies whether the different symptoms of Binge Eating Disorder were fulfilled simultaneously in the past. Ask only if all criteria of BED were fulfilled in the past. The items in the grey

box are meant for a better control. Here you should sum up your previous findings. If not all criteria are fulfilled code 8 and go on to the next question. If criteria A-D were fulfilled, question 52.a is coded.

Code 0 = No

Code 1 = Yes

Code 8 = Does not apply (not all criteria of BED fulfilled)

Question 52.b checks, whether there was compensatory behaviour in the time when criteria A-D were fulfilled. If all criteria were fulfilled simultaneously ask the patient how old she/he was when this was the case for the first time.

Probes: How old were you when all symptoms occurred simultaneously for the first time? (If necessary, sum up: when you had binges, (reported features of criterion B) as well as distress and despair about the binges?)

53. Objective Impairment (at school/at work/in household)

Probes: Was your work performance objectively impaired at work or in your household in times you had problems like ... (symptoms of a disturbed eating behaviour).
Additional probes: Have you been criticized for your lack of achievement? Did the same achievements take more energy? (Examples: frequently absent, lack of concentration, more mistakes) Could you get anything at all accomplished?

Definition: In this item the objective impairment of performance or efficiency is explored and rated by the interviewer. The rating of impairment is made irrespective of possible causes: The impairment of performance must not necessarily be a consequence of an eating disorder; it may well be associated with other symptoms or conditions. Impairment not only includes the area of school or work but also tasks in the household (making a shopping list) and recreational activities (reading a book or newspaper, planning and doing weekend activities). Rated is the actual impairment in different sectors of daily activity - as mentioned - irrespective of the causes. Impairment can result from different things such as lack of concentration, physical weakness, interference with eating binges etc.

Code 0 = No impairment.

Code 1 = Slight objective impairment. About the same achievement as in good times, which, however, takes more effort and energy. The person may get tired, weak or exhausted faster. The task may take more effort because of a lack of concentration or bad physical condition.

Code 2 = Marked objective impairment: Occasionally, the person makes mistakes or cannot perform tasks as usual. Usually these deficits are first noticed by the person him- or herself but other persons may eventually have noticed them, too, and may have mentioned it to the person. Because of impairment the person may occasionally be absent from work; mental or physical symptoms such as exhaustion following eating binges may interfere with work. The person may show general weakness (e.g. tiredness and exhaustion and it is therefore difficult for the person to work continuously without interruption on a full time job).

Code 3 = Severe objective impairment: Mistakes may occur frequently or the person may not be able to complete his or her tasks. Colleagues or superiors at work may have criticized work output and/or quality. The person has been absent from work fairly frequently or has trouble getting work at home done. Lack of

concentration, symptoms of eating disorder, general weakness and other symptoms and conditions interfere with the person's output and performance.

Code 4 = Very severe objective impairment: The person makes mistakes very frequently or is often unable to complete any tasks. The person can hardly do anything at work or at home. Very severe lack of concentration, very severe eating binges or other symptoms or conditions may contribute to the person's very severe inefficiency and impairment to get things done.

54. Age at onset of eating disorder

Probes: At what age was the first onset of your eating disorder as discussed during the interview? (e.g.deviation from normal weight, fear of gaining weight, self-evaluation is unduly influenced by body shape and weight, eating binges, or using measures to counteract weight gain.

The following information should be obtained: a) at what age did the first symptoms of disordered eating occur, b) at what age did the person first meet criteria for a DSM or ICD eating disorder, c) at what age did the person first experience eating binges.

55. Constipation

Definition: Here the real frequency of the bowel movement has to be assessed, irrespective of whether the patient takes laxatives or not. To ask for the use of laxatives may at times help to rate this item. Take into account that normal there is some variation. Regular bowel movement (about once a day) is rated 0, and real constipation (with or without laxatives) over several days as 2, 3 or 4, depending on the degree of severity.

Code 0 = no constipation.

Code 1 = Rarely: The patient has constipation rarely (e.g. on vacation for three or four days) or once a month for two or three days.

Code 2 = Sometimes: The patient has constipation regularly (e.g. on every vacation) or every two weeks for two or three days or once a month for three or four days.

Code 3 = Frequently: Regularly once a week for two or three days or every two weeks for three or four days the patient has constipation.

Code 4 = Very frequently: The person reports having constipation nearly continuous, i.e. nearly continuous the patient can only go the bathroom every two or three days or every week the patient can not go to the bathroom for three or four days.

56. Obsessive-Compulsive Checking

Probes: Did you have to **repeatedly check things** that you had already taken care of, e.g. locks, switches, etc.? How many times? **Did you** have to **touch or count certain things over and over again**, or did you have **to repeat certain actions again and again?**

Additional probes: How many times? What happened when you attempted not to follow your compulsion (fear, anxiety)? How hard was it to resist? Did others notice? Has it interfered with your functioning (e.g. making you late)? Did it bother you a lot that you had to do these things?

Definition: The patient forces him- or herself to repeatedly check light switches or locks on doors or windows more frequently than would rationally make sense, to touch or to count certain things or to repeat certain actions again and again. It is usually rated by considering duration, frequency and intensity of the compulsions during the period assessed in the interview (last 3 months, lifetime). If the patient is hindered from performing the obsessive-compulsive checking behavior he or she feels uneasy or anxious.

When assessing obsessive-compulsive checking it is also important that the person recognizes his or her checking behavior as irrational and/or exaggerated.

Code 0 = No obsessive-compulsive checking.

Code 1 = Slight obsessive-compulsive checking: Obsessive-compulsive checking occurs but does not interfere with everyday life and when the person e.g. for external reasons has to stop the obsessive-compulsive checking ritual there is only mild uneasiness or distress.

> Example: A person checks switches in his home three or four times even though he knows he has checked them before and they must be in the right position. None of his friends know about this checking ritual because in their presence he manages not to do it.

Code 2 = Marked intensity and frequency of obsessive-compulsive checking: At this stage it becomes more difficult to hide the irrational checking behavior from others, who may or may not know about it. If due to external events the person is prevented from doing the obsessive-compulsive checking ritual this causes a marked degree of uneasiness or anxiety.

> Example: A woman could not leave the house alone or in company with her husband without having marked obsessive-compulsive checking rituals. She was aware that these rituals were irrational and knew if and how many times she had checked whether the lights or the oven were turned off and whether the locks at the door were locked. Because of the ritual she had occasionally come late and quite a few times her husband had told her "Stop it now.".

Code 3 = Frequent and/or intense obsessive-compulsive checking: Checking rituals are so frequent or intense that other people have noticed it usually. The checking does take quite a bit of time, sometimes up to several hours a day and the person, therefore, is impaired in every day life activities. Not doing or interrupting the checking ritual leads to severe tension or anxieties.

> Example: When the person has an appointment outside the house it takes the person great effort to leave the house and get there in time; usually she gets there very much (hours) later. The checking rituals are so severe that the person is considerably impaired because of the rituals and may have lost the job because she could not keep the appointments.

Code 4 = Very severe obsessive-compulsive checking: Checking rituals are the major topic of life for the person concerned. The checking rituals take many hours or sometimes all day long. Because of this the person is severely impaired concerning work and social activities.

Example: A student had several checking rituals. For hours every day he was checking whether or not water was turned off because he was afraid the house might get flooded. He could only leave the house after hours of preparations (checking rituals). At very important occasions there were other people available who would help or even force him out of the house. One checking ritual had to do with burning cigarettes. Being a smoker he had to check until late night whether he had stubbed out all cigarettes, so that the house would not start burning.

57. Obsessions about Cleanliness

Probes: Did you take a lot of time for your personal hygiene, e.g. did you **wash yourself repeatedly**, although you knew you were already clean? How many times? Were you afraid of catching diseases? Did you have **other rituals relating to cleanliness?**

Additional probes: What happened when you tried to resist the compulsion (anxiety, fear)? How hard was it to resist? Did others notice? Has it interfered with your functioning (e.g. making you late)? Did it bother you a lot that you had to do these things?

Definition: Excessive cleaning of certain parts of the body (hands, face), showering, cleaning of one's teeth or other cleaning compulsions. The person realizes the absurdity of the excessive cleaning but feels better if he or she performs the compulsion. The person feels that the fear of infection or the repeated washing of the hands or other rituals originate from him- or herself. He or she knows that the cleaning rituals are irrational and may try to resist. A person may avoid touching "contaminated" things or persons; if they have touched them anyway or think they may have touched them the cleaning ritual is started as soon as possible and may take quite some time so that it may interfere with daily activties and duties. Duration, frequency and intensity are to be taken into account for the assessment. When cleaning rituals are chronic and have been going on for a long time the person may have given up attempts to interrupt the cleaning rituals; it then becomes more difficult to explore the degree of uneasiness, tension or anxiety which arises when the compulsive cleaning rituals are prevented or interrupted.

Code 0 = No obsessions about cleanliness.

Code 1 = Slight obsessions about cleanliness: Intensity and frequency of cleanliness rituals are not so high that they might interfere with everyday activities or duties. If cleanliness compulsions are prevented or interrupted there is a slight uneasiness, tension or anxiety.

Code 2 = Marked obsessions and rituals about cleanliness: Cleanliness rituals occur occasionally and there is some interference with everyday activities. Cleanliness rituals have due to their intensity and frequency become more difficult to hide from others. If a cleanliness ritual is prevented or stopped prematurely there is a marked degree of uneasiness, tension or anxiety.

> Example: A 16 year old girl suffered from mild acne. She interpreted it as a sign of bacterial contamination (cleanliness of the skin) and in a deeper sence impurity of her soul. She washed her face about 12 times a day; in doing so she used desinfectants etc. which harmed her skin. The obsessions about cleanliness had generalized to her whole body and she had to take a shower or bath at least three or four times a day. She realized that the cleanliness rituals were basically irrational and exaggerated. They had so far, however, not interfered with her daily activities and duties. Her mother had noticed her behavior and at times talked about it with her. When she did not do the cleaning rituals she felt markedly uneasy and anxious.

Code 3 = Severe obsessions and rituals about cleanliness: Permanent thoughts of the obsession which the patient finds irrational and annoying. Due to the severity of the cleanliness rituals the person is impaired in some of his or her daily activities and duties (e.g. the person is in danger of losing the job because the cleanliness rituals in the morning took so much time that the person frequently came about an hour or more late to work).

Code 4 = Very severe obsessions and rituals about cleanliness: The obsession is the main topic of life for the person concerned. There are very severe impairments in both private and professional life, e.g. the person is not working at his or her former job because cleanliness rituals had interfered so badly. When the person makes attempts to interrupt or prematurely stop the cleanliness rituals a very high degree of uneasiness, tension or anxiety may arise.

58. Obsessive Thoughts

Probes: Did you have unwanted, intrusive, recurrent thoughts (against your own will), **which you couldn't get rid of?**
Additional probes: How often? Has it interfered in your functioning? Has it bothered you a lot that you had these thoughts? Did you have terrible thoughts on your mind, which you could not stop (e.g. the fear or image that you would hurt someone you love)? What happened when you attempted to stop these thoughts? Did you find it difficult to make decisions even about unimportant matters?

Definition: Obsessive-compulsive thoughts occur to a person over and over again and the person can hardly escape these thoughts or stop them. The thoughts are ego-syntonic (different from many psychotic thoughts) and e.g. for a reflective person or therapist the obsessive-compulsive thoughts are in accordance with the person's personality, experiences and conflicts; they may, however, extent to themes of aggressive acts towards others or to scenes with obscene meaning, which at first glance may appear to be in contrast to the person's (socially desirable) behavior towards others. There may be different obsessive-compulsive thoughts or one particular always recurring thought. Duration, frequency and intensity should be taken into account for rating the severity of obsessive-compulsive thoughts. If the content of the obsessive-compulsive thoughts exclusively addresses themes of food, eating and slimness do not rate it here but at the next item (item 28). Obsessive thoughts should be distinguished from depressive brooding, which is rated in item 33.

Code 0 = No obsessive-compulsive thoughts or obsessive brooding.

Code 1 = Slight obessive-compulsive thoughts, which occur rarely and do not interfere with everyday life and duties.

Code 2 = Marked obsessive-compulsive thoughts: Obsessive-compulsive thoughts or obsessive brooding occur occasionally and once they occur may not go away for a while, so that the person may feel frightened, scared, embarrassed or to some extent hopeless. At that stage other people may not know about the obsessive-compulsive symptoms the person has. Usually there is some suffering and when they occur they may slightly interfere with his or her daily activities and duties, however, without negative consequences.

> Example: A 38 year old married accountant repeatedly has the idea that he may not be the biological son of his father and mother. Even though blood tests were done which prooved that this was not the case this and other similar thoughts came repeatedly and disturbed when he had to do work which required much concentration. He recognized these thoughts as irrational and tried to distract himself and stop these obsessive thoughts. They kept recurring however. Although he felt some impairment in his work because of these obsessive thoughts nobody else had noticed it and it so far had had no consequences.

Code 3 = Severe obsessive-compulsive thoughts: The obsessive thoughts occur frequently and last for longer periods of time. They interfere with the person's daily life and duties considerably. The person can, however, still function and with some difficulties may even be active at work or in the household.

Code 4 = Very severe obsessive-compulsive thoughts, which occur so frequently and intense and last for long periods of time so that the person is very much impaired in his or her daily activities and duties. With the obsessive-compulsive thoughts it is impossible to work full days, if the person under certain favourable circumstances has a job. The work output is considerably reduced because of the interfering obsessive compulsive thoughts.

> Examples for obsessive-compulsive thoughts: A mother, who has severe difficulties in expressing her anger, has obsessive thoughts about hurting her child. Another example would be a 20 year old man who

has very strong ties to his mother (father had died long ago); there is nothing (except his obsessive thoughts) he would not tell his mother, who is quite manipulative, strong and tells him what to do as if he were a little boy. At times he feels very angry about this, but has never expressed this towards his mother. Two years ago he started to have obsessive thoughts that she might poison him, which on the other hand he was sure she would not do. He also developed aggressive obsessive thoughts towards his mother (stabbing her all over the body). When he presented for treatment he had such thoughts repeatedly over the day alltogether for about 60 minutes.

59. Compulsive Behavior Concerning Food and Eating

Probes: Did you have fixed eating habits, and was it a problem if you could not follow them? For instance, did you have certain times at which you needed to eat and did not feel as if you could deviate from this pattern?
Additional probes: What if you were invited to a party where food was served; could you deviate from your usual in such a situation? What were your typical eating habits? Has it been important for you to „celebrate" meals in a ritualistic way, to keep to preparations, cover, order, etc.? Did you hoard, weigh or hide food compulsively? Have you been obsessed with collecting recipes? Did you cook for others in a compulsive way?

Definition: There are certain rituals or fixed eating habits. If compulsive behaviors relate to food or eating they should be rated in this item; compuslive behaviors outside eating should be rated in the items 56 or 57. Unusually fixed, sometimes bizarre eating habits, qualitative food reduction (only rolled oats or salad), "celebrating" the preparation of food and eating in a ritualistic way, delaying of eating compulsively and "picking" when eating should be considered here.

Code 0 = No compulsive behavior concerning eating.

Code 1 = Slight compulsive behavior concerning food and eating: There are only a few fixed eating habits or rituals concerning eating, which to others would appear unusual. The person can, however, control these "eating ticks" when necessary (eating in company of others).

Code 2 = Markedly compulsive behavior towards food and eating: There are several fixed eating habits or rituals concerning eating (hoarding of food, collecting recipes, strict planning concerning time/amount/kind of food, order, cover). Slight alterations can hardly be beared. The behavior has a clear compulsive quality.

Example: On first inquiry, patients sometimes report that they only wish to keep to healthy nutrition. On further inquiry, it turns out that they have very strict rules concerning kind of food, preparation and place of origin (e.g. only cereals or vegetables, only raw or steamed, only from the natural food shop), which impair the mobility or social relationships of the persons concerned. Often the strict eating rules are also imposed on the partner and the children, which can lead to severe conflicts.

Code 3 = Severe compulsive behavior concerning food and eating: The behavior very clearly has an obessive quality. The person may have severe problems in social life or other occasions. But it is still possible for the patients to give them up for a very short period of time, if the occasion is very important.

Example: A patient had a strict plan for her nutrition. Every day until the evening she ate exactly the same food at exactly the same time (e.g. 8.00 o'clock a glass of milk and one pretzel, 11.00 o'clock two bananas etc.) In addition, there were rules for her manner of eating (e.g. bananas had to be cut in small pieces or could only be eaten with a pastry fork). In the evenings the patient was "allowed" to eat whatever she wanted and in whatever way she wanted. Not only because of this but also because she could give up her habits for shorter times (e.g. being together with her friend, holiday), here "3" was rated.

Code 4 = Very severe compulsive behavior concerning food and eating: Very bizarre eating habits which are largely alienated from the ususal purpose of eating, or a number of strict eating habits or compulsive rituals concerning eating, which can not be given up without very intense distress or anxieties.

> Example: 22 year old femaly anorexic who still lived at home and who only ate crumbs, apples or tomatoes and refused to eat anything else. Every day she cooked dinner for her parents and her younger sister; she did this in a very compulsive way, counted the calories each of the others had eaten during the meal and became very angry and nasty when the others did not eat as she in her compulsive way expected from them. By doing so she terrorized the family, who was pleased that she did the cooking because all except the anorexic were working all day long. The anorexic person also had a huge supply of food which nobody else of the family was allowed to see or touch.

60. Preoccupation with Food and Eating
IR-BN-B1: Persistent preoccupation with eating

Probes: Have you been preoccupied with thoughts concerning eating, food, cooking, calories?
Additional probes: Were these thoughts very persistent? What percentage of your waking hours were spent thinking about food and eating? Did these thoughts interfere with your life in any way?

This item assesses the frequency and intensity of compulsive thoughts concerning food and the degree of impairment of normal life - the ability to concentrate on other activities.
Measured is the period of time the patients are able to occupy themselves with other tasks without thoughts concerning eating etc. or how much time of the day (percentage) they spend with compulsive thoughts.

Code 0 = Thoughts concerning eating almost only when hungry.

Code 1 = Rarely thoughts concerning eating - ability to concentrate not impaired.

Code 2 = Sometimes thoughts - particularly in unpleasant or boring situations, but long periods without thoughts concerning food are possible.

> Example: A bulimic patient reported that, unless she was working or being active in her leisure time, during symptom-free periods she intensively occupied herself with thoughts concerning eating. In the morning before she went to work, during lunch-break and in the evening the main topic was what she could eat, how many calories the food had and what amount of food was allowed.
> As the thoughts concerning eating immediately disappeared when the patient was distracted, it was not rated higher here.

Code 3 = Frequently thoughts - ability to concentrate impaired, 30-50 % of the day the patients occupy themselves with thoughts concerning eating, but periods of about an hour duration without thoughts concerning eating are still possible.

Code 4 = Very frequently thoughts - permanent thoughts concerning eating resulting in strong impairment of the ability to concentrate, even during activities the patient enjoys; the thoughts take more than 50 % of the day.

61. Preoccupation with Body Slimness, Shape and Weight
(see also SIAB item 10)

Probes: Did you think a lot about your figure and weight and how others might perceive you? Did you weigh yourself frequently?
Additional probes: How often do you weigh yourself? How much time do you spend thinking about your figure and weight? What percentage of your waking hours were spent thinking about your figure and weight? How concerned were you about this?

Definition: This item overlaps with item 16 (body image disturbances). There is an intense desire to be slim, whatever the cost. All events or activities leading to a loss of weight and therefore to slimness are pleasant for the patient; events or activities leading to an increase in weight cause anxiety or unease. Often the patients have idols who they emulate (Twiggy).
It should be asked whether the patient has a certain threshold for her weight and how she would feel if her weight would exceed that threshold. (Does she avoid going into public places because of a feeling of embarrassment or does the patient lose all interest in any activities because of a feeling of ungainliness or uneasiness?) Further enquiries could be how the patient experiences persons who are not slim or how often does she weigh herself.

Code 0 = No preoccupation with body slimness.

Code 1 = Slight uneasiness if a certain desired body weight, which is still normal standard, is exceeded or the desired body weight is somewhat to low.
Mood is not impaired and the patient still takes part in all activities.

Code 2 = Present body weight or deviation from the desired weight has an influence on the self-esteem of the persons concerned. If the body weight is higher (even 3 kg) they report a lower self-esteem and ill-feeling. If their body weight corresponds whith what is desired they have a much more better estimation of themselves.
The desired weight may be lower than the expected weight. The patients do not considerably restrict themselves in their activities, if they are not at their desired weight, but they feel uneasy (e.g. when wearing a bathing suit) and they take counterregulatory measures.

Code 3 = At this rating the strict ideal of slimness shows by the desire for a considerably too low body weight.

Example: The patients report that they are not able to accept a higher body weight or a larger clothing size. If they are fatter they suffer from depression and from an effect of generalization, i.e. they are dissatisfied with their whole life, they are not able to accept good characteristics or aspects of their life and try everything to lose weight. The counterregulatory measures are considerably more rigid than at rating "2" (more measures, more frequently taken). Certain activities, e.g. swimming, are completely avoided.

Code 4 = The strict ideal of slimness is the main concern of these persons. It is the main criterion for their satisfaction in life and their self-esteem. Often this is uncovered only after longer exploration. Mostly patients are daily (often several times a day) occupied with their body weight, check it and orient their activities and their day around it. If they are dissatisfied they avoid activities and contacts with others are drastically impaired.

Example: A stewardess had a desired body weight af 52 kg with a body height of 170 cm. She reported that she had not been able to do her job over long periods of time because of her bulimic symptoms and the resulting deviations in weight (up to 65 kg); she would have been too much ashamed if she would have needed another set of her working clothes.

62. Feelings of Insufficiency and Helplessness

Probes: Did you feel helpless, without hope and think there was no way out of your situation? Were you convinced that everything you could do wouldn't really change anything?
Additional probes: Did you think it was senseless for you to commit yourself to something in life, and that all your efforts wouldn't change anything? Did you feel that you had little control over what happened to you? Did you feel as if you were at the mercy of other persons or powers? In what areas of your life did you feel that you had no control? How pervasive was this feeling?

Definition: This syndrome may in some persons be hidden or masked, as the person's awareness may be reduced by hyperactivity and denial tendency. This syndrome is described by Bruch as an "all-pervasive feeling of ineffectiveness" and it is related to the concept of external locus of control according to Rotter. The patient has the feeling that his or her actions will not change the own destiny, which is in the hands of others. The item is meant in a wide and general but not deep sense and is not at all restricted to feelings of helplessness concerning the eating disorder.

Code 0 = No feelings of insufficiency and helplessness.

Code 1 = Slight feelings of insufficiency and helplessness, which are understandable in the light of certain life situations. A passive attitude is present, until it is overcome after a while.

> Example: Married woman, whose husband had an affair. Sie felt like a helpless victim and thought that she couldn't change anything. Eventually she succeeded in initiating a discussion and in expressing her own wishes.

Code 2 = Feelings of insufficiency and helplessness are not primarily a reaction to temporary life situations, but have become an attitude of the individual at least in certain areas. Motivation to change in these areas may be blocked, because the person has lost confidence in the efficacy of his or her own actions.

> Example: Patient didn't see herself as capable of setting limits for her daughter. She felt that she couldn't assert herself. A score higher than 2 was not given, because only one area was affected.

Code 3 = The individual has severe feelings of insufficiency and a very passive attitude in several areas of life and in many circumstances. This explains the strong feeling of helplessness. A frequently given explanation for difficult situations is "there was no way to change it".

Code 4 = Very severe feelings of insufficiency and helplessness: Life is perceived as meaningless. There is generally pessimistic attitude and the conviction of ones own insignificance. The person believes he or she has no influence at all over the structure of his or her own life.

63. Reduced Perception of Internal Stimuli

Probes: How well could you perceive hunger, satiety and physical pain? How well could you distinguish among different internal feeling states such as sadness and anger?
Additional probes: Did you notice that you had insufficient sensitivity to external coldness or heat (e.g.getting burns from drinking hot beverages without noticing the heat at the moment?) (Hypersensitivity to cold temperature in underweight people does not apply here).

Definition: This symptom, which Hilde Bruch has also emphasized, may at times be difficult to evaluate as the patient can hardly give information about something which he or she may not have noticed. For this reason information from others as well as observations during or outside the interview situation are

important. The interviewer should try to find out if the patient has discovered an unusual perceptual deficit in him- or herself when compared to others. This disturbance in the perception of internal stimuli and emotions pertains to difficulties in perceiving hunger, stomach contractions and in a broader sense, the perception of pain, temperature, tiredness and (importantly) in a very broad sense, the perception of ones own emotions.

Code 0 = No disturbance in the perception of internal stimuli.

Code 1 = Slight disturbance in the perception of internal stimuli: Only one area (eating, pain, feelings) is affected or several areas are only mildly affected.

Example: A person was overeating every now and then , i.e. noticing the limits too late when eating

Code 2 = Marked disturbance of perception: One area of internal perception is clearly disturbed or several areas are markedly disturbed. Persons who had some treatment for their eating disorders are usually more aware of their difficulty in perceiving hunger and satiety. A person may report that he or she does not know when satiated and in order to determine a "normal" portion of food he or she watches, how much other people eat. Other eating disordered persons may eat rigidly at fixed times in order not to forget to eat.

Example: A patient reported that she did not have any feelings of hunger but that she gathered she must be hungry when she heard her stomach growl.

Code 3 = Severe disturbance of perception: Either one area is affected very severely or more than one area is clearly affected.

Code 4 = Very severe disturbance of perception: More than one area severely affected. There is hardly any access to emotions and bodily sensations. One undifferentiated negative affect may be dominant (for example an anorectic patient was sad and whiny but could not differentiate emotions appropriatly. In addition she never felt tired and had black and blue marks from minor injuries, which she hadn't noticed).

Example: A woman reported that she could drink very hot drinks much quicker than other people without feeling the heat; however, she noticed that she got blisters and burns from this in her mouth and larynx.

64. Depressed Mood

Probes: What was your basic mood? How was it at ist worst?

Additional probes: Did you have times when you felt sad or unhappy? Did you often feel like crying? Did you feel desperate and hopeless? Could you get rid of this mood and distract yourself? For how long did the depressed period last? Did this impair your functioning (e.g. work, relationship)? Did you ever receive treatment for depression?

Definition: This item includes all moods of gloominess, despondency and sadness. When the interviewer has the impression that the patient has a pathological, depressive mood he or she should ask further questions to obtain a better evaluation. The symptom is rated on the basis of the severity of the depressed mood and independent of whether or not the patient takes antidepressive medication. Evaluation is based not only on the behavior of the patient during the interview (depressed posture and behavior, sad facial expression), but on all other information available about of the patient's mood. The item is rated independent of item 68 (suicidal ideation). In practice, however, both may in some patients be associated and suicidal ideation be an indicator of (very) severe depressed mood. Depressed mood ideally is also

rated independent of the item on "depressive thoughts" (item 65). A person can have depressed mood and no depressive thoughts or vice versa.

Code 0 = No depressed mood.

Code 1 = Slightly depressed mood: A patient reports having depressive symptoms (joylessness, lack of vitality, decreased appetite, hypersomnia) after separation from a partner with whom she was with for 4 years. The described symptoms can be understood as a normal reaction to the situation and are therefore assessed as slight. It is possible that the separation or the experience of loss was the initial cause of the depressive reaction, but was only the beginning of a developing pathological depressive disorder. A sensitive patient who frequently cries when seeing sentimental movies or hearing music, is generally evaluated with a 1.

> Example (present status): A married 44 year old woman reported some anxiety and depression. She was mainly worrying about her husband, who is a passionate gambler. At the time of the interview she reported feeling more "composed". The family situation had not changed, but she reacted with less fear than she had previously. She was not cheerfull, but had not cried in the past weeks and could deal with daily tasks without problems.

Code 2 = Marked depressed mood: A woman reported that after the death of her mother she couldn't recover from her bad mood and still felt quilty, worthless and sad three years later. It is difficult to say how long a normal reaction to loss "should" last. It is helpful to ask the patient to what degree she thinks she has overcome the loss or if she experiences an increasing amount of grief. In order to code 2, depressive mood should have been present to an extent that outpatient treatment has been considered.

> Example: A 24 year old woman complained that she was very irritable, despondent, cried easily and had little initiative. Her doctor had prescribed her antidepressive medication, which she thought had helped her somewhat. At the time of the interview - which is rated here - she could do her household chores, but found them to be quite strenous. She still felt despondent, found little joy in life, had given up her usual leisure activities such as dancing and found her life boring.

Code 3 or 4 = Severe or very severe depressed mood: Persons to be considered for these higher codes have severe or very severe depressed mood, which is associated with impairments in social relationships, leisure activities or work. Persons with very severe depressed mood, who consequently were unable to work, who isolated themselves from others or who had been treated on an inpatient basis for depression should be coded with "4".

> Example (for code 3): A divorced 64 year old man, who suffered from repeated episodes of depression, was more or less constantly under antidepressive medication. Nonetheless he complained of melancholy and hopelessness and expressed himself as follows during the interview: " I have nothing to look forward to, only another lost day. My life is over". He found nothing which he enjoyed doing, "not even reading". He had no desire to converse, not even with old friends. He had no interest in news or current events. Sometimes he felt better, but during the last two weeks he had generally felt very sad and hopeless.

65. Irrational, Depressive Thoughts and Dysfunctional Cognitive Schemata (Dichotomous Thinking, Overgeneralization)

Probes: Did you tend to see only the negative sides of life? Did you tend to brood over things which you thought you did wrong?

Additional probes: Did you often think according to the "all or nothing-principle" ("if I don't pass the exam, I am a total failure")? Did your negative thoughts easily generalize to other areas? Did you quickly take criticism personally and then feel "totally" down? Did you blame yourself for things that were not your fault? (for code 4, feelings of inferiority and suicidal thoughts may also be present)

Defininition: This category was included to enable the interviewer to judge self-devaluating, destructive or inappropriately pessimistic thoughts of the patient, which can be associated with eating disorders. These thoughts should be rated independently of "depressive mood". Guilt feelings should be coded here and not in item 67 (reduced self-esteem). The same applies to depressive mood or feelings of grief.

Depressed thoughts and brooding should be judged, the latter can also be coded unter "compulsive phenomena".

Code 1 = Slight tendency toward pessimistic or self-deprecating thoughts which are not pathological

> Example: A 78 year old widow reported that she felt well, but tended to think about her past. She became sad when she thought about her husband, who died 6 months ago: "Sometimes I have a good cry". Sometimes she had the impression not to have done enough for him during his illness and these thoughts dampened her spirits. In this situation her mood and thoughts can be seen as part of a normal grief reaction, especially in view of the fact that she needed no medication and was capable of living a normal life. What is rated here in this case is not her mood (grief) but exclusively her depressive thoughts.

Code 2 = Marked and clinically significant depressive thoughts or pathological pessimism of a slight degree; does not include fixed ideas about one's own minority, shame or guilt

> Example: A 61 year old married woman was in psychiatric treatment for several years because of a severe, acute depressive illness. Recently she was treated for an anxiety disorder by her doctor. During the interview she denied being depressed and did not appear dejected. The patient reported that the depression was the result of the end of a relationship to a married man, which her husband had found out about. She felt remorse and hat guilt feelings because of this affair. She still thought about it often.

Code 3 = Strong and clinically significant depressive thoughts or pathological pessimism of considerable degree. Includes patient's fixed ideas about his inferiority, shame or guilt. Suicidal thoughts may be present.

> Example: A patient demonstrated a severe "all or nothing" way of dichotomous thinking. The young woman evaluated herself, her future and the meaningfullness of life according to her grade on exams. She was convinced that if she failed according to her standards that she was superfluous and life meaningless.

Code 4 = Very strong depressive and irrational thoughts: nihilistic illusion or delusional guilt and worthlessness.Delusional or paranoid depressive thoughts are also coded as "4".

66. Reduced Self-Confidence in Performance

Probes: Did you have lack of confidence in your own abilities?

Additional probes: Did you feel awkward and insecure when you were with people because you did not know what to say or do? Did you feel you couldn't handle everyday problems? Examples? Did you think you were not doing well enough (at work or school) despite your grades or other evaluations not indicating this? (for code 4,subject may feel incapable of even simple, familiar daily tasks)

Definition: Self-confidence is best expressed in contact with others: Signs of lack of self-confidence are uncertainty, shyness, reserve. A self-confident person has confidence in his or her capabilities of coping with problems of mastering tasks. In this item self-confidence is assessed generally. Lack of self-confidence may be but is not necessarily associated with eating problems.

Code 0 = No reduction in self-confidence.

Code 1 = Slight reduction in self-confidence: some shyness, uncertainty, awkwardness.

> Example: patient reports having some difficulty in asserting his will, having some difficulty in saying "no" or that he has to give himself a "kick" in order to take the iniative. These difficulties are present, but he can overcome them by himself most of the time.

Code 2 = Marked lack of self-confidence: The lack of confidence impairs the individual to some extent.

> Example: A student reports having difficulty in telling her roommate not to borrow her clothes or other belongings without asking her beforehand. The student experiences impairment and anxiety and much of the time she is unable to defend herself.

Code 3 = Severely reduced self-confidence: The lack of self-confidence impairs the trust in oneself to master daily tasks. There frequently is a discrepancy between the subjective experience of inability and the objective reality of what is required.

> Example: A patient reports that she cannot fulfil the increasing demands at work. After further questionning it becomes clear, however, that her increasing expectations in her own achievements have increased parallel to the competency the patient has gained with increased work experience. She actually can or could fulfil her tasks but lacks the confidence that she can master them.

Code 4 = Very severely reduced self-confidence: The patient totally lacks confidence in fulfilling even very simple and familiar daily tasks.

> Example: A depressed patient who felt totally incapable of running her own household. For every small thing she had to be reasured that she had done it all right and needed prompting for the next step. Her impairment was caused by her extreme lack of self-confidence and not from psychomotor retardation, apathy or depressive stupor.

67. Reduced Self-Esteem

Probes: How would you describe your self-esteem at its worst? Did you often feel inferior or worthless?
Additional probes: Did you judge yourself more negatively in comparison to other people? Did you feel inferior only in certain areas (specify) or in general? Were you incapable of enjoying an activity just for the fun of it because you were so concerned about how well you did it? Was it difficult for you to accept praise or presents because you thought you were undeserving?

Definition: The person feels inferior to others; if very pronounced he or she feels worthless. The reduced self-esteem stems from an overly critical attitude of the patient concerning certain of his own characteristics. For this reason there are distorted views of oneself, which cannot be modified by the knowledge that others people have similar faults. The reduced self-esteem includes unrealistic

expectations of him- or herself without the same expectations of others or without seeing one's own strong points. The symptom is to be coded according to its quality and quantity.
Further indices are: Does the patient compare him- or herself to other people? Does the person think he or she "earned" the affection received from others? How does the person deal with getting presents, compliments or praise? Does the person consider him- or herself likable?

Code 0 = Self-esteem is not reduced.

Code 1 = Self-esteem slightly reduced: The individual compares him- or herself in certain situations or areas of life (e.g. sports) with others and believes him or herself to be inferior, which cannot objectively be confirmed. The person does not have a generalized attitude of being inferior through and through.

Code 2 = Self-esteem is markedly reduced: A tendency to generalize is present; this deals with a general attitude towards oneself.

> Example: A married woman is convinced that she doesn't deserve such a "great person" as her husband. She feels less valueable, attractive and successfull in comparison to him. Although there are several objective indications of her own industriousness and attractiveness, she insists that she is worth less than her husband. Since the woman did not suffer an impairment of her self-esteem in areas in which she could not be compared to her husband (being together with girlfriends) she was not rated higher.

Code 3 = Self-esteem is severely reduced: Such persons feel inferior most of the time and in most areas. They are caught in a viscious cycle of comparison with others and feelings of inferiority. Often it is not possible to undertake an activitity just for the fun of it, as the extreme achievement orientation is constantly present. Praise and presents cannot be accepted or can only be accepted with difficulty.
Persons whose self-evaluations alternate from phases of fantastic overestimation to phases in which feelings of worthless dominate are also to be included here.

Code 4 = Self-esteem is very severely reduced: Persons feel very much inferior, and totally worthless.

> Example: An anorectic patient reports having feelings of not having earned her food. She felt herself and her life were superfluous and totally meaningless.

68. Suicidal ideation (thoughts)

Probe: Did you ever think about committing suicide?
Additional probes: What thoughts did you have? How concrete were these thoughts (i.e. Did you have a plan? What was it?) and how often did you have them?

If the question is answered affirmatively but it remains unclear if these thoughts are serious or only fleeting, the following questions should be asked:

- When did the suicidal thoughts occur? If there are indications of a depressive phase (see items 62 and 64-67) and these thoughts occur simultaneously with other depressive symptoms, then these thoughts are to be considered concrete (2).
- Thoughts and situation should be described conretely

Code 0 = No suicidal thoughts.

Code 1 = Slight and fleeting suicidal thoughts.

Code 2 = Marked suicidal ideation: More exact and concrete suicidal ideas.
alternatively: occasional or frequent suicidal thoughts, but with only a vague plan. Person can clearly distance him- or herself from these thoughts and is certain not to act upon them.

> Example: A person reports: "I sat high above the ground and suddenly had the urge to jump down (and be rid of all problems)". Interviewer: "Were you afraid that you would really do it? Proband: Yes" It was like an inner compulsion. The idea that everything would be over in a few seconds was quite relieving. But then I pictured how I would lay down there with a deformed body. (Code 2, as the idea is concrete).

Code 3 = Severe or frequent suicidal ideation: Frequent suicidal thoughts, whereby concrete plans have been thought about, but not acted upon. Proband cannot always distance himself from the thoughts, as the desire for relief is too great.

Code 4 = Very severe or very frequent suicidal ideation: Very freqent occupation with thoughts about suicide, whereby very concrete plans have been made. Some persons may actually have made very serious suicidal attempts which failed by chance.

> Example: A person has collected poison or pills lethal in larger quantity. Others discovered the poison by pure chance and the person who most certainly would have committed suicide could receive help and support.

69. Suicidal acts

Probe: Did you ever attempt to commit suicide?

Additional probe: What did you do? When did this happen? How often did you make such attempts?

All attempts with an underlying suicidal intent are counted . Even if the act did not lead to death due to lack of knowledge (wrong dosage of pills or incorrectly cutting of arteries). Planning a suicide only (buying pills in pharmacy without ingesting them or hurting oneself) falls into the category 1 or 0.

70. Other self-destructive behavior

Probe: Did you ever hurt yourself intentionally?

Additional probes: How, and how often did you for example injure yourself intentionally with sharp objects like a knife, razor-blade or needle? Did you scratch your skin or bite your finger-nails? What was the worst physical consequence from this self-injurious behavior?

Code 0 = No other self-destructive behavior.

Code 1 = Slightly or rarely other self-destructive behavior: Rarely and without obvious consequences such as bleeding, infections or scars.

> Example: biting fingernails, squeezing pimples, scratching (small wounds are scratched open repeatedly), pinching, pulling hair occasionally, etc.

Code 2 = Marked or occasional other self-destructive acts: As 1, but with marked (= visible) consequences such as bleeding, scar.

Example: Onetime cutting of the arm with a razor blade or burning oneself with an iron would be coded with 2, as the wound and pain are considerable.
Alternatively, frequent occurance of destructive behavior, but without visible consequences

Code 3 = Severe or frequent other self-destructive acts: Frequent occurance with marked consequences, whereby medical attention was not necessarily sought.

Example: A person has cut her left arm (biceps muscle) with a kitchen knife about 1/2 inch deep and it bled a lot.

Code 4 = A person hurts himself very frequent and/or very severely and usually more than once.

Example: A man hurts himself often while masturbating, by inducing vomiting until his throat bleeds, cutting neck or facial area, cutting with pieces of glass.

71. Alcohol abuse

Probes: At the time when you were drinking the most alcohol, how often were you drinking? What kind and how much alcohol did you drink? What was the most you drank in a day? Did alcohol present a problem for you? In what way?
Additional probes: Did you ever have any impairment in functioning because of your alcohol usage? Was there a period of time when you frequently drank more alcohol or drank over longer periods of time than you had planned? Did you develop a tolerance to alcohol? Did you have problems with family members because of your alcohol-consumption? Did you neglect work (or school or go to work/school with a hangover), or did you have withdrawal symptoms such as tremors when you stopped drinking? Did you ever have blackouts? Or any medical complications of alcohol?

The interviewer should not hesitate to ask openly and directly about the consumption of alchohol. Many subjects are willing to talk about their alcohol intake. For ratings of abuse or dependency explore the actual amount consumed as well as the regularity and frequency of drinking, the type of drink (% alcohol) and the attitude towards drinking. The interviewer must at times "help" the memory of the person interviewed. In some cases alcohol problems are disguised and the interviewer will have to "bargain" in exploring alcohol consumption. ("Do you at special occasions drink more than ...?")

Code 0 = Drinks no alcohol in general, with the exception of perhaps a glass of champagne on New Year's Eve or eating a piece of chocolate with alcohol.

Code 1 = "Normal" amount of alcohol or occasional (rare) abuse. "Normal" drinking habits, it is not difficult to refrain from drinking alcohol. Amount of alcohol consumed has no clinical relevance and no negative consequences short- or long-term. If abuse occurs, it does so rarely and in limited quantities.

Example: A subject reports drinking a whole bottle of wine during eating-binges but only about 3 times a year (e.g. birthday, New Year etc.). Despite the large amount, "1" should be coded here, as the wine isn't used for its alcohol content, but as a food which is consumed during a binge (the wine is regurgitated before it can enter the bloodstream, therefore causing no effect).

Code 2 = Marked abuse of alcohol.

Example A: A glass of wine is necessary before going to bed, if there is no wine at home, a replacement must be found. (The subject convincingly reports that she really drinks only one glass, but that she must have it.
Example B: Intoxication or a hang-over occur occassionally or regularly, for example always on weekends, but alcohol does not cause any somatic complaints, social problems or withdrawal symptoms.
Example C: Subject reports having an alcohol problem. Even if the objective amount appears small, the subjective impression of the subject should be considered.

Code 3 = Severe abuse of alcohol or presence of alcohol dependency: Alcohol is a problem (somatic problems or withdrawal symptoms), but social and work areas are not greatly impaired (only some conflicts with partner or friends).

Example: The subject reports: "Yes, I have problems with alcohol. There are phases, in which I drink a lot (until drunk). I can't control my drinking. That leads to conflicts with my partner, is also a theme in my psychotherapy. My performance is not grossly impaired socially, professionally or by my health. A 3 would be coded here, as the alcohol consumption is severe but has not (yet) had disastrous consequences such as being fired at work or separated from partner.

Code 4 = Very severe abuse and physical consequences or severe alcohol dependency: As in 3, but with very substantial influence on work and/or partnership, or severe somatic consequences (e.g. cirrhosis of the liver; organic brain syndrome, hallucinosis, delirium) are present.

72. Minor tranquillizers with potential of addiction

Probe: Did you take any tranquilizers (such as benzodiazepines or barbiturates)?
Additional probes: What kind of tranquilizers did you take and how much (dosage)? How often and over what time period?

Ask about the type of medication, the dosis per day and the length of time for which it was taken. Note the name of the medication so that a specialist can give information if questions arise. Herbal medicines (such as baldrian) and antidepressive medication are not included here. Ask very specific questions: Some subjects may answer "Yes, I take a pill now and then". Ask for more exact information as to what "now and then" means, as it may mean anything from rarely to daily. A rating of "1" means a tranquillizer is rarely or occasionally taken or regularly in (very) low dose and from the context there is no danger of developping dependency. Taking the tranquillizer has no negative significance

73. Drug abuse

Probes: Have you ever smoked marijuana? When you were smoking it the most, how often were you smoking? How much? (How many joints a day)? How long did that go on? **Have you ever used any hallucinogenes or psychedelics, like LSD?** (same follow-up probes as with marijuana). **Have you ever taken amphetamines?** (same probes) **Have you ever taken cocaine or crack?** (same probes) **Have you ever taken morphine, or heroin, or opium?** (same probes).

See also item 71; generally the analogous criteria should be used. In addition consider the time, energy, and money the person is willing to spend to get the drug, as well as the risk he or she is willing to take of getting into conflict with the law.

Marijuana (grass) and hashish are to be evaluated as mild drugs, which only in rare cases would be coded with a 3 or 4, when they lead to conflict with the law or a marked impairment socially or at work.

Examples:

Code 0 = No use of ("illegal") drugs.

Code 1 = Rare or occasional use of a mild drug.

Example: hashish (at the most once per week); the subject can easily do without drugs.

Code 2 = Marked abuse of drugs.

Example: quite frequent use of hashish; if there is none available, the subject may do without it for a while but eventually will become preoccupied with getting some. Using the drug has a function (e.g. to forget problems).

Code 3 = Severe abuse of drugs or signs of dependency on "hard drugs".

Code 4 = Very severe drug abuse or strong dependency on "hard drugs" (very frequently, powerful drugs such as heroin and/or potent drugs in very high dosage or clinical signs of strong dependency („cold“ „turkey") or very severe social consequences resulting from drug dependency).

74. For Juveniles aged below 16 years only:

Probe: Have you ever had a date with a boy/man or girl/woman and did you ever get physically intimate (petting, sex) with another person?

75. Reduction of sexual desire

IR-AN-D: A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis is manifest in women as amenorrhea and in men as a loss of sexual interest and potency.

Probe: Were there times in which your sexual desire was reduced?
Additional probes: How would you compare your sexual desire then with that of other women/men your age? Over what period of time has it been reduced?

Note: A redution of sexual desire can be present even if sexual activity occurs (sexual intercourse with partner). Vice versa, a strong sexual desire can be present in the lack of sexual activity (momentarily no partner). Phases of illness or strong demands in the work area can also temporarily lead to a reduction in sexual desire. Regardless of the cause, the degree of the reduction of sexual libido should be assessed here. It is of no importance for the evaluation if the patient judges the reduced libido positively (for example, anorectics with sexual fears) or negatively. The sexual desire is rated generally; if it is reduced only in specific situations or with a specific partner and not in other situations this is rated as no basic reduction in sexual desire.

The question of how strong the desire for sexual activitiy is in comparison to one's own past or in comparison to peers should be asked first. Then, if libido has been reduced, find out over what period of time this has been so. Further probes are usually more gender-specific (e.g. questions about erections, ejaculations). The frequency of masturbation and the way of dealing with pornography can also be an indicator.

Code 0 = Sexual desire in accordance with that of peers.

Code 1 = Slight reduction: Example: A young woman reports having a chronic flu, which has somewhat reduced her sexual desire in the last three weeks.

Code 2 = Marked reduction: Example: A young woman reports: "When I have eating-binges and feel too fat, I have no desire". A code of "2" is given, even thought there is a strong reduction, as it is not of lasting duration.

Code 3 = Severe reduction of sexual desire: A person reports having a strong reduction over a longer period of time.

Code 4 = Very severe reduction in sexual desire. For some patients with an eating disorder (e.g. anorexia nervosa) having strongly reduced sexual desire, this is often no problem, as they are afraid of sexuality and feel relieved not to feel this desire. Nevertheless, this would be rated as "4" (very severe reduction of sexual desire).

76. Sexual anxieties

Probes: Have you been tense and anxious when you were about to get involved in sexual interactions (kissing, petting, intercourse)?
Additional probes: How sexually intimate could you become with a partner you like, without getting tense or anxious? Did you ever try to avoid sexual contacts completely?

Definition: The interviewer should get an idea of the sexual behavior of the person in the past and present in accordance to the subject's age and willingness to talk about it (see question 78, sexual behavior). Using concrete examples, it should be asked if anxiety arises and how intense the sexual contact must be to lead to such anxiety. By persons who very actively avoid "sexually risky" situations, this item must be very carefully examined and examples in the subjunctive form, for example: "Imaginge yourself in a situation where ..., how would you feel if...?"

Code 0 = No sexual anxieties.

Code 1 = Slight sexual anxieties:

> Example: an 18 year old student had not yet had sexual intercourse. She had a boyfriend, but the relationship so far was platonic. She desired sexuality and wanted to obtain sexual experience. In imagining it she became slightly tense but also curious, as she didn't know what it would be like. A code of "1" was given here. This code should be given when desired intercourse is experienced as only slightly unpleasant, but no real fear exists.

Code 2 = Marked sexual anxieties:

> Example: 24 year old male cook had had intercourse with prostitutes twice. He thought his penis was mal-formed and was afraid to approach a woman. Many subjects report being tense or anxious during sex, because they feared rejection (Partner could find them too fat and therefore unattractive). This should be coded with "2".

Code 3 = Severe sexual anxieties: Avoidance of kissing and intense caressing since it may proceed to intercourse.

Example: 32 year old woman with a childlike manner had never had intercourse. In the past she had experienced kissing, caressing, and petting once, which was very unpleasant for her, and she broke off the relationship. Presently she says she wants to have a partner and is longing for affection. After further questionning, it becomes apparent that she experiences men as protectors and idealizes them. She has no concrete ideas about sexual behavior and no sexual phantasies. Although she has no concrete fears of contact or anxiety when imaginging herself being affectionate with men, her behavior shows that she avoids concrete experiences with sexuality.

Code 4 = Very severe sexual anxieties:

Example: A woman (married, 2 children) reports not being able to tolerate her husband's greeting when he comes home in the evening. Every affectionate touch is unpleasant for her and makes her freeze. A code of 4 is given as she has avoided all physical contact with her husband for 3 years.

77. Relationship to Partner

Probes: Did you have a stable relationship? For how long? How close and stable was the relationship? Were there times in the past when you had no partnership? Did you feel incapable of getting involved in a serious relationship?

Definition: The interviewer should explore if a relationship exists and how appropriate it is for that age. It is not the formal background (e.g. being married) that counts, but the actual relationship to partner. The rating of this item is supposed to be a global evaluation in which several dimensions (age-appropriateness, stability, closeness of the relationship) are summed together. Only the most prominent of these should be used in the evaluation; e.g. if partners change often, but the relationships are relatively healthy, then a code of "2" should be given; a frequent change of partners with more problematic relationships, regardless of type, should be rated with "3". The principle of "maximum pathology in the past" can not simply be applied here, as longer periods of time without a partner doesn't mean that the condition is pathological. The general overall course since early adulthood should be judged in the "lifetime/past" rating here.

For this item the interwiewer should judge the presence and the type of relationship as well as the ability of the subject to form close relationships, so far as these can be determined by behavioral indicators. The explainations after the codes are only examples, the equal sign is not valid in these cases.

Code 0 = a) Subject had stable relationships, and periods without a partner in between, when there was a desire to have a partner.
Example: Subject: "At the moment I am getting along well with my husband. He understands me, and we really have no problems with each other." A sexual relationship no longer exists (last sexual intercourse 10 years ago), but neither partner suffers because of it. A "0" should be rated as there is no indication of tension.
b) stable relationship, good contact, common activities; even if partners do no live together there is frequent contact by telephone or mail and the desire to live together in the long run.

Code 1 = Fairly stable relationship with quite a bit tension. There exists a steady relationships, but with a pathological character, such as dependency, little trust, etc.

Example: Subject can not accept sexuality at all. This leads to tension in the marriage.

Code 2 = Frequent changes of partner or longer periods of time without a partner or having a fairly detached relationship: There is capabilty to form close relationships, but they are transient, close only for short times or detached.

Example: Woman reports having a boyfriend. Both partners live in the same town, but in separate apartments. She finds him unattractive and even repulsive. The relationship has been going on for some years and they see each other several times a week. The woman complains of feeling alone, that her partner does not understand her and that he is not a help or comfort to her.

Code 3 = Very detached relationship with rare contacts. A close relationship is not even temporarily possible. Contacts remain seldom.

Code 4 = No partnership.

Example A: 36 year old man had several "one night stands" but never a closer and lasting relationship with a woman (or man).
Example B: A 32 year old woman had a relationship in the past, but now refuses to think about a relationship and does nothing (or is avoiding everything) that could lead to meeting someone.

Code 8 = Does not apply: This code should be used if the person interviewed is very young and not having had a close relationship is explained by his or her age.

Note: For subjects without a relationship in the the last 3 months, it has been agreed upon to rate with a "4", since no other evaluation is possible at the moment. The code 4 in this case is purely descriptive and not judgemental.

78. Sexual Behavior

Probe: Did you have a sexual relationship?
Additional probe:Did you have intercourse? If not, how sexually intimate were you?

Lifetime: Only judge the times during which a steady relationship existed. If a relationship never existed, and there is no objective reason for that, code with a 4; in this case it can be assumed that the subject's aversion to the opposite sex is made manifest in this way. The example above "good marriage without sexuality" is coded here with 3.

Present Situation: should be judged descriptively, without considering positive or negative emotions. If sexual intercourse has not taken place in the last three months, a "0" can not be given as a rating. An "8" (does not apply) may be given if there is no occasion for sexual intercourse (e.g. hospital stay) or if the patient's young age explains the lack of a sexual relationship.

79. Leisure Activities

Probe: How active were you in your free time?
Additional probe: What did you do? For example hobbies (handicrafts, etc.), political or religious commitments (organizations, parties), sports, theatre, movies, concerts, exhibitions, pubs, outings, walks, reading, or listening to music? How much of your free time did you plan actively? Did you do these things primarily by yourself or with others?

Definition: This item should rate how active the patient is in his leisure time and how he uses it for his own interests. Not only the number of activities and the the time spent on activities is of importance, but the amount of interest he or she develops for them and the fun and satisfaction the person gets out of them.

Regularity in carrying out the activities is not necessarily a criterium, because theoretically, some activities could drop into the background for a while, without the patient having given them up, while others come into the foreground. It is also of importance to what extent the iniative comes from the person.

Code 0 = Active in wide spectrum of leisure activity about daily.

Code 1 = Slightly restricted leisure activities: Subject feels impaired in his or her leisure activities due to profession and/or children. The rating "1" should be given when leisure activites are objectively difficult due to external demands and the subject experiences this as an impairment.

Code 2 = Markedly restricted leisure activities: Subject admits that she has problems taking the iniative in activites or calling friends. She undertakes activites that others (e.g. her husband) have planned. A rating of "2" is given here, as almost no iniative is taken by subject, but she participates in the activities of others.

Code 3 = Severely restricted leisure activities: Subject reports: " I read, knit, take a walk (alone) and watch television". This corresponds to a code of "3", if the proband enjoys these activities and she can at least use her leisure time in this way. She does not undertake activities with others.

Code 4 = Very severely restricted leisure activities: Subject in the mid thirties, married without children, who does not work and has no social obligations, reports having no time to do anything for herself. Her day is filled with housework, shopping, cooking, etc which take up all her time. A rating of 4 can be given here, because no leisure time is available, although it is most likely possible.

80. Extent of social contacts

Probes: How many contacts did you have with friends and acquaintances? How often did you see each other and what did you do together?
Additional probes: What was the frequency of your social contacts with people outside your family and partnership?

Definition: In this item it is evaluated to what degree the patient is capable of forming a minimum on social contacts. Three areas are included here.

1. superficial friends or acquaintances with whom he spends leisure time

2. contacts to neighbors

3. close friends or confidants with whom he talks about personal matters.

In each of these areas it should be ascertained to how many people the patient has contact and of what nature this contact is (personal, telephone or by mail). An appropriate degree of social contacts (rating 0) is defined by at least one close friend, whom the patient sees regularly and several acquaintances or superficial friends or neighbors that the patient has frequent contact with (at least once a month). The different gradations of an inappropriate degree of social contacts can be determined by a combination of superficial and close friends as well as the frequency of the contacts with them. Life circumstances such as "a move to a new city", which could account for having few contacts, should be taken into consideration, and would in this case not be evaluated as pathological.

Code 1 = "Only common acquaintances with partner, no friends of one's own.

Code 2 = "Only superficial relationships", even if they are numerous should be coded as "2".

Code 3 = "Only superficial relationships, which change often" or "Only a relationship to partner" should be coded as "3".

Code 4 = "Lives with parents, no other contacts" should be coded as "4".

81. Quality of social contacts

Probes: Did you have somebody whom you could trust entirely, and who was always there for you whenever you needed help, comfort or support? Was there someone with whom you could discuss just about everything?

Definition: Of what nature are the contacts outside the family? Is there one or more persons to whom the patient has an open and honest relationship with trust, understanding and reliability? Can the patient be comforted by this person or give comfort to him? Can she talk about her eating disorder?
The significant person can also be a partner or therapist.

Code 0 = Has very close confident: A close friend is present with whom the subject can talk even about very personal problems.

Code 1 = A friend is present with whom the subject can not talk about "everything".

Code 2 = A friend is present, but the subject reports there is little real trust or that the friend can not really help or support him.

Code 3 = The relationship is either very distant or of pathological nature, such as dependency on one another or sharing the same destiny. This is not evaluated as a real friendship and should be coded with 3.

Code 4 = Neither superficial interactions with a friend nor a confiding relationship.

82. Avoidance of social contacts

Probes: Was there ever a time when you avoided contact with other people? Did you experience anxiety? Were you suspicious of other people?
Additional probes: To what extent did you withdraw from being around other people? Did you withdraw from everyone or did you still spend time with close friends or family?

Code 1 = Slight withdrawal or avoidance of contacts: Subject feels uncomfortable with contacts and would prefer to avoid them or seeks no contacts herself.

Code 2 = Marked withdrawal or avoidance of contacts: Subject rejects contacts herself, for example not answering the telephone or partially not accepting invitations.

Code 3 = Severe withdrawal or avoidance of contacts: Subject is only willing to talk to the closest or best friends.

Code 4 = Very severe withdrawal or avoidance of contacts: rejects contact even to family members or persons who are open and helpful.

83. Denial of illness

Probe: How strong was your eating disorder at its worst?
Additional probes: At the time when you had the eating disorder, did you think that you were ill and needed help? Which of the things you told me before made you worry the most?

Definition: Essential for the evaluation of this item is the discrepancy between the evaluation of the illness by the patient's standards and the evaluation by the interviewer. The interviewer should ask the patient to what degree and in what way he feels sick. Often there is no sense of illness concerning the eating disorder, but patients suffer from other symptoms such as anxiety (in the social area or fear of becoming fat), depressive thoughts or complaints that seem hypochondriacal. It is necessary during the interview to find out to what extent the patient experiences major symptoms of the eating disorder (such as fasting, vomiting, abusing laxatives, marked underweight) as pathological and to what extent he suffers from them.
An extremely underweight patient who openly talks about vomiting, depressive mood and sleeping disorders and who convincingly (in the view of the interviewer) reports feeling sick and seeing him- or herself as ill would be rated with "0" in this item despite the severe disorder (no denial of illness).
Indicators could be: Motivation for treatment. Does the patient think he or she needs help and treatment? Does the person deny symptoms? Does the person she admit having problems, while denying the central problems in the area of eating behavior?

As far as possible, the rater should judge (for the "past") if there was a time when the patient could not and did not want to see the problems he or she had regarding eating behavior.

Code 0 = The subject reports all the symptoms which were shown to be clinically relevant in the interview and recognizes these as her problems. There is no denial of illness.

Code 1 = Subject recognizes that her eating behavior is not normal, although this doesn't bother her and she shows no motivation to change it. She may have advantages from her illness. If the problems are clearly recognized and can be articulated, but the motivation for therapy is missing, code with a "1".

Code 2 = Subject sees her eating behavior as problematic, but due to a fear of gaining weight (which she does not recognize as pathological), she doesn't want to change it. A "2" should be coded here, as typical symptoms of the eating disorder are not recognized as such.

Code 3 = Subject sees her underweight as "normal". She believes her problems with eating have other causes. She doesn't regard her problems as an eating disorder. A code of "3" should be given here; although problems are recognized, the eating disorder as such is denied.

Code 4 = When the existence of problems is denied, a rating of 4 should be given. This will generally become obvious in the course of the interview through patient's understatements.

84. Global Evaluation of symptoms

Probes: In eating disorders symptoms can be present such as an exaggerated **ideal of slimness, dieting, overconcern with body weight and shape, thoughts centered around eating, disturbed eating behaviour, absence of menstruation** in women, **deviations from normal weight, fear of losing control** while eating, episodes of **binge eating,** (self-induced) **vomiting, laxative abuse, excessive exercising, social isolation** as a consequence of the eating disorder. To what extent were all or some of these symptoms present?

Definition: In this item a global evaluation of the severity of the eating disorder should be established. Take into account that eating disorders can be classified into categories: Anorexia nervosa, Bulimia nervosa, Binge eating disorder, Atypical eating disorder/Eating disorder NOS; make a compound rating for the global severity of the eating disorder irrespective of the specific diagnosis.

The criteria for the assessment are given in the interview. Difficulties can arise when additional symptoms (depression, concentration problems, compulsive symptoms) arise, which are more or less associated with the eating disorder and may occassionally be more severe than the eating disorder.
The global evaluation of the symptoms is so designed that all relevant symptoms evaluated in this interview are included in the rating The assessment is thus not limited to disorders in eating behavior. Individual compulsions or fears are, however, not considered.

Code 0 = No eating disorder.

Code 1 = A slight eating disorder is present, which, in the opinion of the interviewer, can be dealt with without treatment.

Code 2 = A marked eating disorder is present. Social and work areas are on the whole not impaired greatly. Outpatient treatment is usually sufficient.

Code 3 = A severe eating disorder is present, which leads to a marked impairment in work and social areas. More intensive outpatient therapy or inpatient treatment are usually advisable.

Code 4 = Very severe eating disorder- the disorder has become the center of the person's life. A complete inability to work has (in most but not all cases (AN)) resulted and the social network has completely fallen apart. An inpatient admission to a hospital is strongly recommended.

85. Differential Diagnosis and Additional Mental Disorders

Whether or not important other mental disorders are present should be evaluated here. This is expecially important for the diagnostic classification (especially for scientific purposes). If besides the eating disorder there are signs of a psychosis, this should be carefully assessed on hand the appropriate questions. Likewise organic brain syndromes should be evaluated in detail, especially their role in triggering or perhaps even causing the eating disorder.

86. List of Substantial Physical Illness According to ICD 10 (e.g. acute thyroiditis - E 06.0)

87. Prescription of psychiatric drugs

Probes: Which **prescriptive psychotropic medication** (**antidepressants**, **neuroleptics**, etc.) have you taken for a longer period of time (two weeks or more continuously)?

All psychotropic drugs (especially neuroleptics or antidepressants) taken in the relevant time period should be listed here. To be included are the name of the the medication, the dosis and the length of time taken, regardless of the probable indication. Drugs which require no prescription are not to be listed!

3.3 Special instructions for the application of the SIAB-EX to adolescents (B. Herpertz-Dahlmann)

The formulations of the SIAB-EX primarily are aimed at the understanding of adult persons. At some universities (Marburg, Wuerzburg, Aachen) the SIAB-EX was used with adolescents. The following section gives modifications to some items of the SIAB-EX which may be more appropriate for the use with adolescents. These modifications take better into account the psychosocial developmental state of youths and are appropriate for age 14 or older. However, these modifications must be considered provisional and are not yet validated.

Item 1: Deviance from normal body weight
Concerning this item it must be considered that anorexia nervosa in adolescents may be expressed in a lack of weight gain while the body height increases. It is recommended toget additional information on this issue from the parents.
Qu.: What was your lowest, what your highest weight since you reached your present height? Did your parents or some other people ever told you you are much too thin? How old were you when this happened? Do you remember your body weight at that time?

Item 3: Internal achievement orientation
Most eating disordered adolescents will not be working on a regular basis. School education is the most important area especially in anorexic adolescents.
Qu.: Which type of school are you visiting? What year? How important are good grades for you? How was your feeling after getting a low grade? Did you have little time for your friends because you had so much to do for school? Did you neglect your hobbies in order to have more time for school work? Are you very ambitious concerning achievement in sports? Are there other areas where it was very important for you to be one of the best?

Item 4: Anxieties
Emotions related to anxiety are often labeled in another fashion than is be done by adults.
Qu.: Are you often excited? Do you feel nervous many a time? Do you sometimes feel anxious without any obvious reason? Do you suffer sometimes a panic attack? At these occasions did you feel giddy or dizzy or like fainting? Did you feel like being short of breath

or having a pounding heart? Did you fear going crazy or dying? Did your fear have effects on your behavior, e. g. minding your health or avoiding situations causing fear?

Item 5: Phobias
Besides phobic anxiety sepoaration anxiety should be explored which is often found in eating disordered adolescents.
Qu.: Do you hate to separate from your parents? Do you prefer to be with your parents instead of being with your friends?

Item 6: Sleep disorders
Sleep disturbances are often found in adolescent eating disordered patients.
Qu.: Do you have difficulties to fall asleep in the evening? Do you awake in the night? Did you ever check the clock to see how long you lay awake in the night? How early did you awake in the morning?

Item 7: Fear of gaining weight or getting fat
In some cases it could be necessary to use more simple formulations. Notice should be taken of the fact that a weight gain of 3 to 5 kg in three months for an adolescents means a greater relative weight gain than for an adult.
Qu.: Do you fear to get fat? How would you feel, if you gained 2-4 kg (=5-9 pounds) of weight within three months (anxious or panic stricken)? Did you ever feel anxious about weight gain? What did you do to deal with this anxiety (e.g. increase exercise or decrease food intake or purge)? How would you have felt if you would have gained just 1 or 2 pounds within three months?

Item 10: Dependence of self-evaluation and self-esteem on body shape and weight
Qu.: Is there a relation between your weight or figure and your self-esteem? Do you think peopla would like you more if you were thinner? Do you feel to be better accepted by your friends if you had a slim figure?

Item 11: Dieting or fasting
Often eating disordered adolescents skip lunch or dinner because the amount of calories included is not calculable for them.
Qu.: Did you skip lunch or dinner because you thought your mother did not care to calories while preparing the meal or you did not know how many calories were in the meal? Do you prefer to eat alone in order to be able to save on calories? Did you diet or fast during the day and eat only in the evening?

Item 12: Avoidance of fattening food and selective eating

It is recommended to name the fattening food directly.
Qu.: Did you avoid sweets/chocolate/ice cream/fries, did you scratch or drop the butter on the bread in order to avoid weight gain? Did you prefer to eat yoghurt, curd or fruits?

Item 16: Body image disturbances
Due to body image disturbance adolescents often avoid age appropriate activities which are done with light clothing.
Qu.: Do you avoid going swimming because you feel you are too fat? Did you not wear clothes (e. g. mini skirt) because you think they present you as too fat? Did your friends (your mother) consider your figure in another way than yourselve? Do you often look in the mirror in order to control the size of your stomach or your thighs?

Item 17: Denial of the seriousness of the low body weight
Qu.: Do you think your low weight is dangerous for your health? Do you feel physically worse since you are so thin? Do you have any ideas why your low weight could be dangerous for your body?

Item 19: Menstruation
Notice should be taken that in adolescent females menstruation often is not regular without being a sign of ovarious insufficiency.

Item 21: Eating binges
It is recommended that with adolescents the questions should be formulated more directly.
Qu.: Did you experience episodes of binge eating during which you ate a large amount of food in a relatively short period of time, e. g. sweets, cookies, several slices of bread one after the other etc.? Did you feel afterwards exhausted or sick? How often did you have eating binges? How looked the binges like? What and how much did you eat during an eating binge?

Item 26: Sense of lack of control with regard to eating
Qu.: During an eating binge did you feel you could no longer control what and how much you were eating? Would it have been very difficult or even impossible during a binge to answer the phone or to open the door? Did you ever steal food for a binge or take food from waste receptacles? During a binge did you eat unusable things like pet food, pure butter or spoiled food?

Item 27: Characteristics of the eating binges
Part 5 of the question could be supplemented by the following:
Qu.: Did you feel guilty towards your parents after an eating binge because you had emptied the refrigerator?

Item 28: Binging and Distress
Qu.: Did you feel worried or even desperate about the binges? Are you worried that the binges will sweep over you and you are unable to cope? Do you feel worreid that the binges may make you ill?

Item 34: Craving for food
Name food typically consumed by adolescents, e.g. snacks sweets, cookies.
Qu.: If you tried to resist these urges, how uncomfortable did you feel?

Item 35: Vomiting
Additional qu.: Did you induce vomiting by inserting your finger into your mouth or by drinking a great amount of liquid in order to facilitate vomiting?

Item 36: Laxative abuse
Additional qu.: Did you take laxative teas in order to avoid weight gain?

Item 41: Excessive fasting
We propose to define excessive fasting for adolescents as abstaining from food for more than 12 hours.

Item 42: Excessive exercise
Many eating disordered adolescents do achievement oriented sports. Some visit a fitness center in order to lose weight.
Qu.: How much physical exercise are you doing? Do you feel uncomfortable if you are prevented from exercising regularly? Is it unbearable for you to sit quiet for a long time? Do you sometimes contract your muscles in order to exercise while sitting? What types of exercise did you engage in? Do you engage in achievement oriented sports? Do you visit a fitness center in order to lose weight. How many hours a day? Do you do ballet or jazz dancing or aerobics in order to change your weight or shape? How often? Have there been times when you declined opportunities to be with friends in order to exercise? Have you engaged in sports or exercised to burn up calories and to toughen and trim your body?

Item 49: Type of anorexia nervosa
Special care should be taken to avoid using professional medical language.

Item 53: Objective impairment at school/at work/with household
Mostly in adolescents this items will refer to school.
Qu.: Did your grades in school deteriorate during the time you had problems with eating like... (fasting, binges, vomiting)? Did your teachers talk to you about a change in your grades? ? Did the same achievements take more energy than in times when you had no eating problems? Were you frequently absent from school? Did you have difficulties with concentrating on tasks?

Item 56:

4. SIAB-S self-rating questionnaire

4.1 General description of the SIAB-S questionnaire

The self-rating form of the SIAB (SIAB-S) offers an economical way to gather data on eating disorders and how subjects experience their own eating disorder and other symptoms. The SIAB-S questionnaire may be used as the basis of a diagnostic interview. E. g. it may be mailed to a person and returned by him or her before the first face to face contact. In a similar way the SIAB-S may be used for gathering baseline data in longitudinal clinical studies or in psychotherapy to document the course of an eating disorder. The SIAB-S covering the same areas as the expert interview SIAB-EX simplified diagnoses according to DSM-IV or ICD-10 based on the self-rating may be made. In epidemiologic studies the SIAB-S may be used for screening to identify high or low risk groups in the population. For screening purposes the definition of a cut-off value of the sum scores or the definition of diagnoses may be suitable.

4.2 Content and application of the SIAB-S questionnaire

The self-rating SIAB-S and the expert-rating SIAB-EX are structured in an identical way. The SIAB-S covers the same areas as the SIAB-EX. The numerical order is identical to the SIAB-EX (e. g. item 7 in the self-rating and in the expert-rating version refers to weight phobia).

Like in the SIAB-EX the results for most items of the SIAB-S are coded on a five-point scale ranging from 0 (symptom/problem not present) to 4 (symptom/problem very severely present). Generally the scale is defined as follows:

0 = symptom/problem area not present
1 = symptom/problem area slightly or rarely present
2 = symptom/problem area markedly or sometimes present
3 = symptom/problem area severely or frequently present
4 = symptom/problem area very severely or very frequently present

For most items the cross-sectional status (was the symptom present in the last 3 months) and the maximal expression of the symptom in the past is rated by the proband. The past rating will usually cover the time from prepuberty up to 3 months before the interview. The present status covers the maximal expression of the symptom/problem area in the last 3 months before the interview, if not specified otherwise. The SIAB-S will take about 30 minutes to fill out.

For the analysis of the subscale structure of the SIAB-S principal component analysis with varimax-rotation was done including all items used for the analysis of the SIAB-EX. Items referring to atypical binges (items 29, 30, 31 and 33) were excluded from analyis. These items were added to the SIAB only recently. Therefore not enough cases for analysis were available. In order to get factor solutions which were comparable to the analysis of the SIAB-EX PCA was done separately for the current and the past status. 5- and 6 factor solutions were explored. Results showed that the best solution for the past status comprised 6 factors (table 20) which explained 48 % of the variance (I: 25.6%; II: 6.4%; III: 5.3%; IV: 4.3%; V: 3.6%; VI: 2.8%). Based on theoretical reasons, item 41 (excessive fasting) was moved from factor III (slimness ideal) to factor VI (inappropriate compensatory behaviors to counteract weight gain, substance abuse, fasting and aautoaggression), and item 3 (achievement orientation) was moved from factor V (body image) to factor III. A seventh factor (atypical binges) was added. Some items which were added to the SIAB only recently and were not included in PCA, were added to the factors in a way analogous to the SIAB-EX.

Insert table 20 about here

For the present state a 5-factor solution seemed to be best. The five factors explained 40.7 % of the variance (I: 19.9%; II: 7.5%; III: 5.5%; IV: 4.3%; V: 3.5%). Due to theoretical reasons item 71 was moved from factor IV (sexuality and body weight) to factor V (inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse). For the current status, too, a factor covering atypical binges was added. Some items which were added to the SIAB only recently and were not included in PCA, were added to the factors in a way analogous to the SIAB-EX (table 21).

Optionally for the definition of the subscales of the SIAB-S the subscales as defined by the SIAB-EX may be applied.

Insert table 21 about here

4.3 Scoring of the SIAB-S questionnaire

In order to avoid creating uncertainty in the probands the items in the self-rating questionnaire SIAB-S contain no codes with the information, whether the item is essential for DSM IV (D) and ICD 10 Research Criteria (IR) diagnostic classification. Scoring sheets are provided as a convenient way of calculating sum scores. On the scoring sheets items are tabulated by factor to which they belong. The ratings from the interview are copied to the scoring sheet and summed up. Some ratings have to be modified before being entered into the coding sheet (e. g. the body mass index is classified in certain categories before being entered into the sum of the factor) which is noted on the scoring sheet. Please see figure 2 for an example.

Insert figure 2 about here

With the SIAB-S the same diagnoses can be made as with the SIAB-EX. For items which are coded from 0 to 4 values of 1, 2, 3 or 4 are generally considered to meet the diagnostic criteria. This differs from the diagnostic procedure used with the SIAB-EX. For such items for which diagnostic criteria can only be met by codes 2, 3 or 4 (e. g. frequency of binges) values of 2, 3 or 4 only are included in the diagnostic algorithm. For details see the diagnostic classification sheets of the SIAB-S.

For the computation of the sum scores and for diagnostic classification according to DSM-IV and ICD-10 computer algorithms are available.

4.4 Interpretation of the SIAB-S questionnaire

Diagnoses derived from the SIAB-S are clinically relevant indicators for an eating disorder. High sum scores of the subscales are an important indication for the presence of an eating disorder and comorbidity (depression, anxiety). Attention should be paid that current status and past status do not overlap but are separate time periods. For the interpretation of the past symptom expression no consideration must be given to the last three month while for the interpretation of the current status only information on the three last months is considered. For a lifetime rating (worst ever) the maximum of the current and past symptom expression should be used.

4.5 Statistical data on the SIAB-S questionnaire

4.5.1 Objectivity of the SIAB-S

The questionnaire SIAB-S should be filled out in an indisturbed atmosphere with no interference from others. It is essential that enough time for filling out is granted in order to allow the proband to give an appropriate rating of each area. Analysis of the results is strictly standardized and as a rule will be made by using computer algorithms. No analysis and diagnostic classification is subject to interpretation by the interviewer. Norms for clinical groups will guide interpretation of the results of the SIAB-S.

4.5.2 Reliability of the SIAB-S

Subscale intercorrelations

Subscales of the SIAB-S showed marked intercorrelations (table 22).

Insert table 22 about here

The scales covering binges (bulimic symptoms, atypical binges) correlated highly (now: .75; past: .72). Correlations of the total score and the subscales were high and varied between .41 and .87. Low (below .20) correlations were observed for the following combinations (present status): Bulimic symptoms with sexuality and body weight; atypical binges with general psychopathology and social integration; body image and slimness ideal with atypical binges; and inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse with atypical binges. Expectedly intercorrelations are higher for the past status, only atypical binges with sexuality and social integration, and atypical binges with body image showed correlations below .20.

Internal consistency

Cronbach's alpha was computed for the subscales of the SIAB-S (see table 23). The coefficients for the past status were high and varied between .69 and .94. The subscales body image, general psychopathology, and the total score proved to be especially consistent.

Insert table 23 about here

Coefficients for the current status laid – with one exception - between .74 and .92. The same subscales as for the past status showed especially high coefficients. A remarkable low coefficient was found for the subscale inappropriate compensatory behavior to counteract weight gain, fasting, substance abuse and autoaggression. A similar result was found for the SIAB-EX. This subscale seems to be more heterogeneous. Reasons may be that 1) this scale integrates diverse areas of behavior as the name of the subscale implies, and 2) compensatory behaviors differ considerable among themselves.

Dependence of the results of the SIAB-S on proband characteristics

There was no relevant influence of age, school education and duration of illness on the results of the SIAB-EX subscales for current and past symptom expression (table 24). Body weight, however, correlated negatively with the subscale body image. A lower but marked positive correlation was found for atypical binges and body mass index. Both results were not unexpected.

Insert table 24 about here

Comparison of the expert-rating and self-rating forms of the SIAB

Conformity of the results of the SIAB-EX and the SIAB-S was researched by computing kappa coefficients. For details see tables 16 (past) and 17 (now) above. Generally a moderate agreement (correlations between .3 and .6) was found between the expert-rating and the self-rating of analogous items. Cohen's kappa varied between .4 and .8 and showed a good agreement.

Higher expert than self-ratings (i. e. t-test significant and differences between means at least 0.2) were found for the past and present state for body image disturbance, factor III (sexuality and social integration), avoidance of sexual contacts, loss of libido, global assessment of eating disorder symptoms, objective impairment, binges (objective and subjective), and quantitative food reduction. For the past status this was true for preoccupation with food and eating, denial of the seriousness of underweight, sexual anxieties, partner relationship, quality of social contacts, factor IV (bulimic symptoms), vomiting, factor V (inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse), excessive fasting, laxative abuse, and alcohol abuse.

According to the same criteria higher self than expert-ratings were found (now and past) for slimness ideal, chewing and spitting out food, achievement orientation, lack of self-confidence, depressive thoughts, depressive mood, anxieties, obsessive thoughts, phobias, compulsive checking, binging and distress, tranquilizer abuse, factor VI (atypical binges), frequency of atypical binges (3 months and 6 months), stress-induced eating, feeling comfortably full after eating, and (only for now) factor I (body image and slimness ideal), weight phobia, compulsive behavior concerning food and eating, excessive exercise, setting caloric limits, obstipation, factor II (general psychopathology), lack of self-esteem, feeling of insufficiency, suicidal acts, denial of illness, extent of social contacts, atypical binges, and the

total score. Contradictory results (higher expert than self ratings for past status and higher self-rating than expert-rating for the current status) were seen for qualitative food reduction, sleep disturbance, suicidal thoughts, leisure activities, social withdrawal, and frequency of binges (3 and 6 months). So a clear pattern of behavior when being interviewed and when filling out the questionnaire emerges: 1. Higher expert than self-ratings are found in eating disordered patients for a) disturbed eating behavior, b) disturbed attitudes concerning food and eating, and c) questions concerning social interaction. Higher self than expert-ratings are found in a) questions referring to non eating-related psychopathology, and b) questions concerning disturbed behavior related to eating binges. As a conclusion there are behaviors which are more readily reported in an expert interview and behaviors which are more readily reported in a self-rating questionnaire. Divergent tendencies for patients with anorexia nervosa and bulimia nervosa were - according to any practical standards - non-existent (see tables 18 and 19).

Suitability of the SIAB-S as a diagnostic screening instrument

To check the suitability of the SIAB-S as a diagnostic screening instrument the DSM-IV diagnoses anorexia nervosa and bulimia nervosa were determined according to the SIAB-S diagnostic algorithm. The sample were 279 persons with an anorexia nervosa or bulimia nervosa according to the DSM-IV diagnostic algorithm for the SIAB-EX (worst ever status, i. e. past and current status combined). 194 of the 279 persons with a defined eating disorder were correctly classified by the SIAB-S algorithm. 78 of the 98 persons without an eating disorder according to the SIAB-EX algorithm were correctly classified as having no eating disorder by the SIAB-S algorithm. This was a diagnostic sensitivity of the SIAB-S for anorexia nervosa or bulimia nervosa of 0.70 and a specifity of 0.80. Positive predictive value was very high with 0.91. Sensitivity for the SIAB-S for the current status was 0.52, specifity 0.86 and the positive predictive value 0.72. The corresponding values for the past status were 0.56 (sensitivity), 0.82 (specifity), and 0.90 (positive predictive value).
Predictive power of the SIAB-S may be increased by dropping criterion C of anorexia nervosa (body image disturbance or denial of illness) and dropping criterion C of bulimia nervosa (frequency of binges and inaapropriate compensatory behaviors) from the diagnoses. Both criteria are difficult to explore by self-rating questionnaires. Dropping these criteria results in a sensitivity of 0.72, 0.60 and 0.59, a specifity of 0.76, 0.81 and 0.78, and a positive predictive value of 0.89, 0.70 and 0.88 (worst ever, now, past, respectively).
Another way of identifying eating disorder cases is the use of sum scores of the SIAB-S. Analyses showed a cut-off of 1.3 for the SIAB-S total score to best differentiate anorexia nervosa and bulimia nervosa from an eating disorder not otherwise specified (according to the SIAB-EX DSM-IV algorithm) in in-patients (sensitivity of the SIAB-S 0.79, specifity 0.66 and positive predictive value 0.86). The best cut-off for the current status was also 1.3 for the SIAB-S total score with a sensitivity of 0.73, specifity of 0.63 and positive predictive value of 0.58).
As described the SIAB-S offers two variants of diagnostic screening. The first described is especially suited for identifying major eating disorders (anorexia nervosa, bulimia nervosa) while using sum scores may be advantageously used in epidemiologic studies in the general population.

4.5.3 Validity of the SIAB-S

Comparing the subscales of the SIAB-S with the expert interview Eating Disorder Examination (EDE, Fairburn & Cooper, 1993) resulted in high correlations of the SIAB-S total score with all subscales of the EDE (table 25).

Insert table 25 about here

The EDE total score, too, correlated with nearly all subscales of the SIAB-S. An exception was SIAB-S atypical binges which showed significant correlation with EDE eating concerns only. Low correlations were found between SIAB-S sexuality and body weight and all EDE scales except EDE restraint, which is plausible. SIAB-S bulimic symptoms correlated lowly with EDE weight concern and EDE shape concern, and highly with EDE eating concern.

Correlations of the SIAB-S with the Eating Disorder Inventory (EDI-2; Garner, Olmsted & Polivy, 1983; Garner, 1991), the Three Factor Eating Questionnaire (TFEQ; Stunkard & Messick, 1985), the Hopkins Symptom Checklist (SCL-90-R; Derogatis, Rickels & Rock, 1976) the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), and the PERI-Demoralization Scale (PERI-D; Dohrenwend, Shrout, Egri & Mendelson, 1980) mare listed in tables 26 (now) and table 27 (past). As all self-rating questionnaires referred to the current status results for this time point will be commented on.

Insert tables 26 and 27 about here

Convergent validity

SIAB-S general psychopathology and social integration:
This subscale correlated very highly with nearly all subscales of the EDI which refer to personality. Correlations with SCL-90 scales were moderate while very high relationships to BDI and PERI-Demoralization could be found.
SIAB-S bulimic symptoms:
The similar constructs EDI bulimia, TFEQ disinhibition and TFEQ hunger showed very high correlations with this SIAB-S subscale.
SIAB-S body image and slimness ideal:
High correlations were found with the EDI total score, EDI drive for thinness and TFEQ cognitive control. Lower correlations were found with EDI interoceptive awareness and EDI asceticism.
SIAB-S sexuality and body weight:
Generally the coefficients were low, values above .30 were found for EDI inefficiency, EDI asceticism, TFEQ cognitive control, and BDI.
SIAB-S inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse:
There are no corresponding constructs in the questionnaires used for comparison. Therefore only low correlations were found. The correlations with the EDI total score and the subscales drive for thinness, inefficiency, interoceptive awareness, asceticism, and impulse regulation were somewhat higher.
SIAB-S atypical binges:
Remarkable correlations were found with EDI bulimia, TFEQ disinhibition and TFEQ hunger. Lower correlations were observed for EDI total score and EDI impulse regulation.

Discriminant validity

SIAB-S general psychopathology and social integration:
Low correlations were found with the TFEQ subscales and – somewhat less markedly – with the eating disorder related subscales of the EDI.
SIAB-S bulimic symptoms:

Except with the scales mentioned above (convergent validity) there were no high correlations with any other scale.
SIAB-S body image and slimness ideal:
Low relationships were observed with TFEQ disinhibition and TFEQ hunger and all subscales of the SCL-90. Correlations with most scales of the EDI and the BDI were higher.
SIAB-S sexuality and body weight:
There are no relevant relationships.
SIAB-S inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse:
This scale did not correlate with the subscales of the TFEQ and SCL-90. Higher correlations with BDI and PERI-Demoralization were observed.
SIAB-S atypical binges:
No relationships were observed with the EDI subscales, TFEQ cognitive control, BDI, PERI-Demoralization and SCL-90.

Summing up the SIAB-S scales may be characterized like this: General psychopathology and social integration covers psychopathology expressed in depressive symptoms, eating disorder related aspects play a minor role. Bulimic symptoms and atypical binges cover very narrowly eating binges (cf. EDI bulimia) and loss of control (TFEQ disinhibition and TFEQ hunger). Body image and slimness ideal relate to restrained eating and weight phobia. This subscale is clearly separated from bulimic symptoms and general psychopathology. Evidence on the convergent validity of sexuality and body weight is scarce because no suitable comparison could be made. Low correlations with the scales used may hint at a good construct validity. Inappropriate compensatory behaviors to counteract weight gain, fasting and substance abuse does not correlate with eating disorder related scales. As these behaviors are not covered by the EDI and the TFEQ this results speaks for a good differentiation of the SIAB-S subscale. This subscales seems to cover partially depression.

4.5.4 Norms

Tables 16 to 19 give comparison values for the SIAB-S. Description of the sample is provided in the corresponding section on the SIAB-EX. Norms are also given for anorexic and bulimic subsamples.

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Table 1: Comparison between number of diagnoses (SIAB-EX) according to DSM-IV and ICD-10 (N= 82)

a) now

DSM-IV / **ICD-10**	**No diagnosis**	**AN restrictive type**	**AN Binge eating/purging type**	**BN**
No diagnosis	41 50.0%	2 2.4%	1 1.2%	5 6.1%
Atypical AN	1 1.2%	3 3.7%	3 3.7%	0
BN	5 6.1%	0	1 1.2%	17 20.7%
Atypical AN + BN	0	0	3 3.7%	0

b) past

DSM IV / **ICD-10**	**No diagnosis**	**Exclusively AN restrictive type**	**AN Binge eating/purging type**	**AN restrictive and AN binge eating/purging type**	**AN+BN**	**BN**
No diagnosis	18 22.0%	2 2.4%	0	0	0	1 1.2%
Atypical AN	1 1.2%	9 11.0%	2 2.4%	1 1.2%	0	0
BN	3 3.7%	0	1 1.2%	0	1 1.2%	18 22.0%
Atypical AN + BN	0	3 3.7%	4 4.9%	3 3.7%	15 18.3%	0

AN = Anorexia nervosa, BN = Bulimia nervosa

Table 2: Intercorrelations of SIAB-EX subscales

a) now SIAB-EX	N	GenPsy Soc	Sex	Bul	Compen-satory behavior	Atyp. Binge	Total
Body Image and Slimness Ideal (BI)	377	.40**	.35**	.20**	.55**	-.21**	.69**
General Psychopathology and Social Integration (GenPsySoc)	377	--	.39**	.36**	.36**	.03	.82**
Sexuality (Sex)	377	--	--	.14**	.22**	-.06	.54**
Bulimic Symptoms (Bul)	377	--	--	--	.19**	.12*	.65**
Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and, Substance Abuse (Compensatory behavior)	377	--	--	--	--	-.13*	.56**
Atypical Binges (Atyp. Binge)	377	--	--	--	--	--	.07

b) past	N	GenPsy	SexSoc	Bul	Compen-satory behavior	Atyp. Binge	Total
Body Image and Slimness Ideal (BI)	377	.35**	.46**	.24**	.39**	-.19**	.69**
General Psychopathology and Social Integration (GenPsySoc)	377	--	.52**	.32**	.54**	.13*	.78**
Sexuality (Sex)	377	--	--	.29**	.38**	.08	.76**
Bulimic Symptoms (Bul)	377	--	--	--	.36**	.16**	.62**
Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and, Substance Abuse (Compensatory behavior)	377	--	--	--	--	.13*	.68**
Atypical Binges (Atyp. Binge)	377	--	--	--	--	--	.19**

*p < .05; ** p < .01

Table 3: Internal consistency of the SIAB-EX

	Past			Now		
	n	Number of Items	Cronbach Alpha	n	Number of Items	Cronbach Alpha
Body Image and Slimness Ideal (BI)	97	16	0.86	80	18	0.82
General Psychopathology (GenPsy, past) General Psychopathology and Social Integration (GenPsySoc, now)	370	14	0.87	363	19	0.88
Sexuality and Social Integration (SexSoc, past) Sexuality (Sex, now)	353	12	0.78	360	4	0.75
Bulimic Symptoms (Bul)	99	8	0.93	98	9	0.93
Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)	98	11	0.64	97	11	0.52
Atypical Binges (Atyp. Binge)	288	4	0.80	287	4	0.77
Total Scale	89	65	0.93	72	65	0.92

Table 4: Correlation between SIAB-EX subscales and several sociodemographic variables

a) now SIAB-EX	**N**	**BI**	**GenPsy Soc**	**Sex**	**Bul**	**Compen-satory behavior**	**Atyp. Binge**	**Total**
Body weight (BMI) (past)	374	-.58**	-.18**	-.18**	-.12*	-.26**	.29**	-.35**
Body weight (BMI) (now)	375	-.59**	-.07	-.13*	-.13*	-.31**	.35**	-.30**
Duration of eating disorder	374	-.31**	.03	-.12*	-.13*	-.18**	.20**	-.16**
Age	377	-.24**	.10*	-.11*	-.12*	-.19**	.13*	-.11*
Education	163	.18	-.13	.01	-.02	.04	.02	--

b) past	**N**	**BI**	**GenPsy**	**SexSoc**	**Bul**	**Compen-satory behavior**	**Atyp. Binge**	**Total**
Body weight (BMI) (past)	374	-.69**	-.13*	-.29**	-.10*	-.12*	.35**	-.37**
Body weight (BMI) (now)	375	-.61**	-.07	-.26**	-.10*	-.03	.38**	-.30**
Duration of eating disorder	374	-.29**	.13*	-.04	-.08	.14**	.21**	-.04
Age	377	-.28**	.14**	-.07	-.13*	.12*	.10	-.08
Education	163	.25	-.11	.01	.01	-.03	-.02	--

*p < .05; ** p < .01
BI=Body Image and Slimness Ideal; GenPsy=General Psychopathology; SexSoc=Sexuality and Social Integration; Bul= Bulimic Symptoms; Compensatory behavior= Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse; Atyp.Binge= Atypical Binges; GenPsySoc=General Psychopathology and Social Integration; Sex=Sexuality;

Table 5: Correlations between SIAB-EX subscales (now) and the subscales of the expert-rating Eating Disorder Examination (EDE) (N = 80)

	BI	*GenPsy Soc*	**Sex**	**Bul**	**Compensa-tory behavior**	**Atyp. Binge**	**Total**
Eating Disorder Examination (EDE)							
Restraint	.73**	.38**	.21	.28*	.69**	-.05	.61**
Eating Concern	.48**	.54**	.21	.61**	.47**	.31**	.72**
Weight Concern	.37**	.44**	.24*	.23*	.35**	.20	.48**
Shape Concern	.52**	.56**	.38**	.27*	.42**	.15	.62**
EDE Total scale	.67**	.61**	.32**	.45**	.62**	.19	.77**

* p < .05; ** p < .01
BI= Body Image and Slimness Ideal, GenPsySoc= General Psychopathology and Social Integration; Sex=Sexuality; Bul=Bulimic Symptoms; Compensatory behavior= Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse; Atyp. Binge= Atypical Binges

Table 6: Overview over the diagnostic congruence of the SIAB-EX and EDE (N = 80)[1]

DSM-IV now	**Fulfilled according to SIAB-EX and EDE** **N (%)**	**Not fulfilled according to SIAB-EX and EDE** **N (%)**	**Fulfilled according to SIAB-EX Not fulfilled according to EDE** **N (%)**	**Not fulfilled according to SIAB-EX Fulfilled acording to EDE** **N (%)**
AN criterion A	24 (30.0)	44 (55.0)	11 (13.8)	1 (1.3)
AN criterion B	40 (50.0)	16 (20.0)	10 (12.5)	14 (17.5)
AN criterion C	63 (78.8)	7 (8.8)	10 (12.5)	0 (0.0)
AN criterion D	33 (41.3)	33 (41.3)	2 (2.5)	12 (15.0)
AN diagnosis	10 (12.5)	60 (75.0)	5 (6.3)	5 (6.3)
BN criterion A	39 (48.8)	18 (22.5)	3 (3.8)	20 (25.0)
BN criterion B	44 (55.0)	23 (28.8)	7 (8.8)	6 (7.5)
BN criterion C	28 (35.0)	23 (28.8)	5 (6.3)	24 (30.0)
BN criterion D	58 (72.5)	7 (8.8)	13 (16.3)	2 (2.5)
BN criterion E	60 (75.0)	10 (12.5)	5 (6.3)	5 (6.3)
BN diagnosis	13 (16.3)	47 (58.8)	12 (15.0)	8 (10.0)
AN or BN diagnosis[2]	27 (33.8)	31 (38.8)	9 (11.3)	13 (16.3)

AN = Anorexia nervosa; BN = Bulimia nervosa
[1] Reported is the number of persons, who fulfilled the criterion or the diagnosis.
[2] Because cases with the diagnosis of AN and BN are also counted in cells which are discrepant between the SIAB-EX and the EDE, the reported number of AN and BN diagnoses does not sum up to the numbers reported in this line.

Table 7: Correlations between single items of the SIAB-EX and the EDE (items of the Restraint Scale)

Item No.		Restraint over eating	Avoidance of eating	Empty stomach	Food avoidance	Dietary rules
	I Body Image and Slimness Ideal (BI)					
7	Fear of gaining weight or getting fat – weight phobia	.29**	.05	.41**	.39**	.48**
10	Dependence of self-esteem on figure and weight	.16	-.18	.23*	.14	.20
12	Qualitative food-reduction	.47**	.19	.30**	.69**	.62**
13	Limits for caloric intake	.35**	.10	.26*	.51**	.56**
16	Body image disturbance	.24*	.22*	.39**	.46**	.32**
42	Excessive exercise	.28*	.24*	.31**	.34**	.17
59	Compulsive behavior concerning food or eating	.33**	.14	.14	.44**	.40**
60	Preoccupation with food and eating	.24*	.04	.38**	.36**	.32**
61	Preoccupation with body slimness, figure and body weight	.11	-.13	.30**	.35**	.18
	IV Bulimic Symptoms (Bul)					
21a	Binging – objectively	.07	.01	.38**	.00	.01
21b	Binging – subjectively	.22*	.09	.33**	.10	.11
23	Average frequency of marked eating binges over a period of 3 months	.13	.04	.34**	.06	-.06
26	Loss of control with regard to eating	.09	-.04	.25*	.07	.14
35	Self-induced vomiting	.19	.12	.39**	.11	.07
	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)					
11	Dieting or fasting - quantitative food reduction	.41**	.18	.32**	.55**	.62**
36	Laxative abuse	.15	.18	.32**	.33**	.22*
41	Excessive fasting	.15	.11	.31**	.39**	.28*
	VI Atypical Binges (Atyp. Binge)					
29	Atypical eating binges	-.06	-.09	.15	-.02	-.18
31	Average number of marked atypical binges	-.01	-.07	.08	.10	-.13
	-- Additional items					

24	Frequency of marked eating binges over a period of 6 months	.11	.03	.37**	.09	-.09
32	Frequency of marked atypical eating binges over a period of 6 months	.02	-.05	.11	.12	-.10

* p < .05; ** p < .01; varying N. Correlations were calculated after the items had been recoded according to the rules of the particular interview into 0 (not clinically significant) or 1 (clinically significant).

Table 8: Correlations between single items of the SIAB-EX and the EDE (items of the Eating Concern Subscale)

Item No.		Proccupation with food, eating, or calories	Fear of loosing control over eating	Social eating	Eating in secret	Guilt about eating
	I Body Image and slimness ideal (BI)					
7	Fear of gaining weight or getting fat – weight phobia	.36**	.32**	.21	.14	.32**
10	Dependence of self-esteem on figure and weight	.04	-.05	.00	.19	.18
12	Qualitative food-reduction	.28**	.26*	.37**	.18	.27*
13	Limits for caloric intake	.23*	.08	.24*	.10	.20
16	Body image disturbance	.30**	.13	.22*	.21	.20
42	Excessive exercise	.03	-.03	.15	-.02	.07
59	Compulsive behavior concerning food or eating	.20	.12	.22*	.01	.24*
60	Preoccupation with food and eating	.41**	.24*	.36**	.32**	.38**
61	Preoccupation with body slimness, figure and body weight	.22*	.02	.20	.04	.08
	IV Bulimic Symptoms (Bul)					
21a	Binging – objectively	.20	.44**	.25*	.45**	.26*
21b	Binging – subjectively	.20	.44**	.25*	.40**	.31**
23	Average frequency of marked eating binges over a period of 3 months	.13	.49**	.42**	.53**	.18
26	Loss of control with regard to eating	.28**	.55**	.38**	.43**	.39**
35	Self-induced vomiting	.20	.50**	.48**	.52**	.20
	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)					
11	Dieting or fasting - quantitative food reduction	.25*	.14	.32**	.12	.26*

36	Laxative abuse	.25*	.05	.30**	.10	.27**
41	Excessive fasting	.24*	.23	.29**	.22	.33**
	VI Atypical Binges (Atyp. Binge)					
29	Atypical eating binges	-.06	-.03	.00	.30**	.03
31	Average number of marked atypical binges	.00	.05	-.01	.33**	.21
	-- Additional items					
24	Frequency of marked eating binges over a period of 6 months	..15	.40**	.45**	.51**	.16
32	Frequency of marked atypical eating binges over a period of 6 months	.03	.09	.02	.37**	.24*

* p < .05; ** p < .01; varying N. Correlations were calculated after the items had been recoded according to the rules of the particular interview into 0 (not clinically significant) or 1 (clinically significant).

Table 9: Correlations between singele items of the SIAB-EX and the EDE (Weight Concern Scale)

Item No.		Dissatis-faction with weight	Desire to lose weight	Reaction to prescribed weighing	Preoccu-pation with shape or weight	Impor-tance of weight	Impor-tance of weight month 2	Impor-tance of weight month 3
	I Body Image and slimness ideal (BI)							
7	Fear of gaining weight or getting fat – weight phobia	-.16	.17	.33**	.33**	.08	.05	.03
10	Dependence of self-esteem on figure and weight	.33**	.26*	.12	.30**	.40**	.39**	.38**
12	Qualitative food-reduction	-.08	.07	.21	.17	.11	.07	.04
13	Limits for caloric intake	.06	.09	.10	.28**	.13	.14	.10
16	Body image disturbance	-.02	.14	.14	.31**	.06	.08	.05
42	Excessive exercise	.13	.07	.01	.25*	.17	.17	.11
59	Compulsive behavior concerning food or eating	-.01	-.00	.03	.15	.02	-.03	-.10
60	Preoccupation with food and eating	.12	-.04	.16	.20	.13	.11	.10
61	Preoccupation with body slimness, figure and body weight	.16	.25*	-.13	.40**	.27**	.26*	.24*
	IV Bulimic Symptoms (Bul)							
21a	Binging – objectively	.04	.21	.21	.10	.05	.08	.06
21b	Binging – subjectively	-.01	.16	.15	.16	.16	.19	.16
23	Average frequency of marked eating binges over a period of 3 months	.09	.23*	.07	.06	.07	.09	.07
26	Loss of control with regard to eating	.02	.18	.24*	.18	.09	.11	.09
35	Self-induced vomiting	-.18	-.01	.11	-.04	-.07	-.04	-.02

	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)							
11	Dieting or fasting - quantitative food reduction	.00	.06	.27*	.25*	.17	.15	.12
36	Laxative abuse	-.01	.20	-.04	.33**	-.01	.00	.01
41	Excessive fasting	.11	.26*	.18	.32**	.12	.13	.07
	VI Atypical Binges (Atyp. Binge)							
29	Atypical eating binges	.00	.20	-.12	-.13	.13	.14	.16
31	Average number of marked atypical binges	.21	.15	-.03	-.09	.15	.16	.18
	-- Additional items							
24	Frequency of marked eating binges over a period of 6 months	.17	.31**	.05	.04	.09	.11	.09
32	Frequency of marked atypical eating binges over a period of 6 months	.19	.12	-.01	-.06	.13	.14	.16

* $p < .05$; ** $p < .01$; varying N. Correlations were calculated after the items had been recoded according to the rules of the particular interview into 0 (not clinically significant) or 1 (clinically significant).

Table 10: Correlations between single items of the SIAB-EX and the EDE (Shape Concern Subscale)

Item No.		Dis-satis-faction with shape	Pre-occu-pation with shape or weight	Impor-tance of shape	Impor-tance of shape month 2	Impor-tance of shape month 3	Fear of weight gain	Fear of weight gain month 2	Fear of weight gain month 3	Discom-fort seeing body	Avoi-dance of exposure	Fee-lings of fatness	Fee-lings of fatness month2	Fee-lings of fatness month 3	Flat sto-mach
	I Body														
7	Fear of gaining weight or getting fat – weight phobia	.10	.33**	.23*	.23*	.23*	.35**	.35**	.35**	.19	-.02	.20	.17	.11	.31**
10	Dependence of self-esteem on figure and weight	.22*	.30**	.34**	.34**	.34**	.18	.18	.18	.30**	.19	.29*	.21	.23	.33**
12	Qualitative food-reduction	.15	.17	.17	.17	.17	.28**	.28**	.28**	.05	.26*	.03	.04	.01	.34**
13	Limits for caloric intake	.23*	.28**	.15	.22*	.15	.28**	.28**	.28**	.11	.20	.09	.11	.09	.28*
16	Body image disturbance	.08	.31**	.22*	.22*	.17	.27**	.27**	.27**	.10	.03	.36**	.35**	.31**	.40**
42	Excessive exercise	.08	.25*	.14	.13	.06	-.01	-.01	-.01	.16	.11	.08	.04	.02	-.06
59	Compulsive behavior concerning food or eating	.21	.15	.27*	.21	.21	.21	.21	.21	.23*	.26*	-.04	-.02	-.04	.13
60	Preoccupation with food and eating	.29**	.20	.33**	.33**	.33**	.44**	.44**	.44**	.21	.11	.11	.06	.08	.44**
61	Preoccupation with body slimness, figure and body weight	.19	.40**	.41**	.35**	.35**	.29**	.29**	.29**	.23*	.07	.28*	.24	.26*	.28*
	IV Bulimic Symptoms														
21a	Binging – objectively	-.19	.10	.11	.16	.11	.11	.11	.11	-.04	-.03	.12	.10	.07	.40**
21b	Binging – subjectively	-.08	.16	.16	.21	.16	.16	.16	.16	.07	-.03	.12	.10	.07	.40**
23	Average frequency of marked eating binges over a period of 3 months	-.18	.06	.05	.11	.11	.21	.21	.21	-.04	-.09	.16	.15	.18	.40**
26	Loss of control with regard to eating	-.04	.18	.09	.14	.14	.20	.20	.20	.11	.06	.14	.13	.09	.37**
35	Self-induced vomiting	-.23*	-.04	-.07	-.02	.04	.20	.20	.20	-.20	-.31**	-.10	-.10	-.13	.36**

	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)														
11	Dieting or fasting - quantitative food reduction	.12	.25*	.12	.12	.12	.28**	.28**	.28**	.09	.10	.12	.10	.06	.26*
36	Laxative abuse	.08	.33**	.20	.20	.20	.28**	.28**	.28**	.17	.11	.20	.17	.15	.29*
41	Excessive fasting	.04	.32**	.16	.16	.09	.23*	.23*	.23*	.13	.08	.21	.18	.16	.15
	VI Atypical Binges (Atyp. Binge)														
29	Atypical eating binges	-.10	-.13	-.03	-.03	.03	.09	.09	.09	.11	-.11	.18	.22	.12	.17
31	Average number of marked atypical binges	-.00	-.09	-.01	-.01	-.01	.05	.05	.05	.14	.04	.28*	.34**	.23	.20
	-- Additional														
24	Frequency of marked eating binges over a period of 6 months	-.16	.04	.07	.12	.12	.23*	.23*	.23*	-.02	-.07	.16	.15	.18	.47**
32	Frequency of marked atypical eating binges over a period of 6 months	.05	-.06	.03	.03	.03	.10	.10	.10	.13	.02	.28*	.34**	.23	.20

* p < .05; ** p < .01; varying N. Correlations were calculated after the items had been recoded according to the rules of the particular interview into 0 (not clinically significant) or 1 (clinically significant).

Table 11: Correlation between single items of the SIAB-EX and the EDE (Additional items 1)

Item No.		Objective bulimic episodes (days per month)	Objective bulimic episodes (days per month 2)	Objective bulimic episodes (days per month 3)	Objective bulimic episodes (number of episodes)	Objective bulimic episodes (number of episodes month 2)	Objective bulimic episodes (number of episodes month 3)	Subjective bulimic episodes (number of days)	Subjective bulimic episodes (number of episodes	Objective overeating (number of days)	Objective overeating (number of episodes)	Subjective overeating (number of days)	Subjective overeating (number of episodes)	Dietary restriction outside bulimic episodes (weeks)
	I Body Image and Slimness Ideal (BI)													
7	Fear of gaining weight or getting fat – weight phobia	.26*	.15	.11	.27**	.14	.06	.19	.20	-.08	-.26*	-.02	-.13	.03
10	Dependence of self-esteem on figure and weight	-.09	-.07	-.09	.02	-.10	-.10	.04	.08	.12	-.12	.02	-.02	.16
12	Qualitative food-reduction	.05	.19	.07	.01	.15	.12	.17	.18	-.18	-.21	.01	-.15	-.00
13	Limits for caloric intake	.03	.16	.13	.03	.12	.14	.24*	.14	-.20	-.29**	-.05	-.08	.00
16	Body image disturbance	.11	.27*	.21	.04	.15	.12	.14	.15	-.11	-.24*	.14	.02	.10
42	Excessive exercise	-.13	-.06	-.05	-.07	-.06	-.04	.06	-.01	.05	-.01	.01	-.09	-.14
59	Compulsive behavior concerning food or eating	-.14	-.03	-.07	-.16	.07	-.03	-.04	-.05	-.03	-.12	.00	.02	-.04
60	Preoccupation with food and eating	.26*	.31**	.28**	.22*	.11	.15	.18	.24*	-.17	-.32**	.07	-.04	.06
61	Preoccupation with body slimness, figure and body weight	.13	.01	.04	.14	.02	.06	.26*	.31**	-.07	-.11	.07	-.04	.10
	IV Bulimic Symptoms (Bul)													
21a	Binging – objectively	.44**	.34**	.25*	.57**	.43**	.35**	.15	.18	.12	-.01	-.05	-.13	.21
21b	Binging – subjectively	.33**	.29**	.20	.46**	.38**	.30**	.30**	.31**	.04	-.13	-.13	-.20	.21
23	Average frequency of marked eating binges over a period of 3 months	.48**	.41**	.31**	.63**	.48**	.50**	.10	.21	.05	-.05	-.11	-.11	.19
26	Loss of control with regard to eating	.45**	.41**	.27**	.59**	.46**	.38**	.30**	.37**	.04	-.13	-.05	-.13	.15
35	Self-induced vomiting	.61**	.52**	.42**	.60**	.51**	.47**	.18	.30**	-.14	-.15	-.12	-.15	.05
	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)													

11	Dieting or fasting - quantitative food reduction	.20	.23*	.14	.11	.07	.05	.31**	.26*	-.21	-.38**	.03	-.06	-.08
36	Laxative abuse	-.05	-.01	.01	.06	.07	.08	.14	.07	-.14	-.20	.07	.07	-.05
41	Excessive fasting	-.02	.14	.02	.12	.18	.12	.19	.20	-.04	-.14	-.07	-.14	.20
	VI Atypical Binges (Atyp. Binge)													
29	Atypical eating binges	.22*	.22*	.13	.03	.06	.08	.16	.21	.19	.14	-.13	-.22*	-.04
31	Average number of marked atypical binges	.14	.16	.07	.03	.02	-.03	.19	.25*	.22	.18	-.12	-.12	.17
	-- Additional items													
24	Frequency of marked eating binges (6 months)	.47**	.34**	.29**	.61**	.39**	.42**	.09	.20	.05	.01	-.20	-.19	.15
32	Frequency of marked atypical eating binges over a period of 6 months	.16	.19	.10	.06	.06	.01	.21	.27	.23*	.12	-.11	-.11	.19

* p < .05; ** p < .01; varying N. Correlations were calculated after the items had been recoded according to the rules of the particular interview into 0 (not clinically significant) or 1 (clinically significant).

Table 12: Correlations between single items of the SIAB-EX and the EDE (Additional items 2)

Item No.		Dietary restriction outside bulimic episodes month 1	Dietary restriction outside bulimic episodes month 2	Dietary restriction outside bulimic episodes month 3	Self-induced vomiting number of days	Self-induced vomiting number of episodes	Self-induced vomiting number of episodes, month 2	Self-induced vomiting number of episodes Month 3	Laxative misuse number of days	Laxative Misuse Number of episodes	Laxative misuse number of episodes month 2	Laxative misuse number of episodes month 3
	I Body Image and slimness ideal (BI)											
7	Fear of gaining weight or getting fat – weight phobia	.56**	.54**	.41**	.16	.26*	.19	.15	.24*	.29**	.26*	.28**
10	Dependence of self-esteem on figure and weight	.16	.15	.15	-.20	-.21	-.20	-.10	.11	.14	.12	.13
12	Qualitative food-reduction	.46**	.48**	.45**	.13	.22*	.17	.15	.12	.24*	.34**	.29**
13	Limits for caloric intake	.24	.26*	.25*	.01	.18	.17	.15	.23*	.22*	.19	.25*
16	Body image disturbance	.47**	.43**	.39**	.13	.25*	.18	.05	.27*	.36**	.30**	.33**
42	Excessive exercise	.29*	.31*	.20	-.09	-.04	-.12	-.13	.30**	.30**	.26*	.33**
59	Compulsive behavior concerning food or eating	.25*	.27*	.24	-.06	-.00	.00	-.02	.19	.34**	.26*	.31**
60	Preoccupation with food and eating	.50**	.40**	.49**	.33**	.33**	.30**	.37**	.20	.24*	.22*	.23*
61	Preoccupation with body slimness, figure and body weight	.27*	.17	.27*	-.05	-.10	-.14	-.12	.19	.15	.12	.14
	IV Bulimic Symptoms (Bul)											
21a	Binging – objectively	.16	.14	.08	.45**	.55**	.55**	.41**	.09	.17	.20	.22*
21b	Binging – subjectively	.06	.03	-.03	.39**	.45**	.45**	.31**	.09	.17	.28**	.22*
23	Average frequency of marked eating binges over a period of 3 months	.28*	.18	.27*	.50**	.61**	.64**	.61**	.02	.12	.14	.17
26	Loss of control with regard to eating	.16	.14	.08	.41**	.47**	.47**	.44**	.10	.18	.20	.23*
35	Self-induced vomiting	.23	.13	.08	.81**	.90**	.84**	.76**	.08	.11	.11	.15

	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)											
11	Dieting or fasting – quantitative food reduction	.49**	.60**	.42**	.16	.18	.12	.14	.28*	.34**	.31**	.33**
36	Laxative abuse	.37**	.38**	.28*	-.06	.08	.07	.06	.65**	.84**	.71**	.78**
41	Excessive fasting	.33**	.34**	.31*	-.03	.22*	.21	.13	.22*	.35**	.30**	.38**
	VI Atypical Binges (Atyp. Binge)											
29	Atypical eating binges	.07	.02	.00	.13	.13	.14	.12	.03	.04	.09	.06
31	Average number of marked atypical binges	.04	.06	.01	.12	.06	.07	.06	.05	-.02	.02	-.01
	-- Additional items											
24	Frequency of marked eating binges (6 months)	.31**	.22	.30*	.48**	.59**	.57**	.54**	.01	.11	.14	.16
32	Frequency of marked atypical eating binges over a period of 6 months	.09	.10	.06	.14	.09	.11	.09	.06	-.01	.03	.00

* $p < .05$; ** $p < .01$; varying N. Correlations were calculated after the items had been recoded according to the rules of the particular interview into 0 (not clinically significant) or 1 (clinically significant).

Table 13: Correlations between single items of the SIAB-EX and the EDE (Additional items 3)

Item No.		Diuretic misuse number of episodes	Intensive exercising to control shape or weight, number of days	Intensive exercising to control shape or weight, number of days month 2	Intensive exercising to control shape or weight, number of days month 3	Number of weeks (3 months) with abstinence from extreme weight-control behavior
	I Body Image and Slimness Ideal (BI)					
7	Fear of gaining weight or getting fat – weight phobia	.09	.25*	.22*	.24*	.03
10	Dependence of self-esteem on figure and weight	.04	.15	.15	.16	.11
12	Qualitative food-reduction	.15	.24*	.20	.23*	-.06
13	Limits for caloric intake	-.07	.40**	.27*	.32**	-.13
16	Body image disturbance	.13	.21	.16	.20	-.01
42	Excessive exercise	-.05	.55**	.49**	.55**	-.00
59	Compulsive behavior concerning food or eating	.18	.27*	.30**	.27**	-.00
60	Preoccupation with food and eating	.07	.27*	.26*	.27*	-.02
61	Preoccupation with Body slimness, figure and body weight	-.18	.26*	.25*	.26*	.06
	IV Bulimic Symptoms (Bul)					
21a	Binging - objectively	.10	-.14	-.18	-.15	.06
21b	Binging - subjectively	.10	-.06	-.11	-.07	.06
23	Average frequency of marked eating binges over a period of 3 mnths	.11	-.10	-.13	-.09	.16
26	Loss of control with regard to eating	.10	-.05	-.10	-.06	.07
35	Self-induced vomiting	.12	-.10	-.08	-.11	-.10
	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior)					

11	Dieting or fasting - quantitative food reduction	.10	.31**	.28**	.30**	-.12
36	Laxative abuse	.30**	.14	.05	.03	-.12
41	Excessive fasting	-.05	.20	.01	.09	.15
	VI Atypical Binges (Atyp. Binge)					
29	Atypical eating binges	.19	.00	-.07	-.09	-.12
31	Average nmber of marked atypical binges	-.06	-.06	-.13	-.14	.05
	-- Additional items					
24	Frequency of marked eating binges over a period of 6 months	.10	-.11	-.14	-.10	.12
32	Frequency of marked atypical eating binges over a period of 6 months	-.06	-.05	-.12	-.13	.06

* p < .05; ** p < .01; varying N. Correlations were calculated after the items had been recoded according to the rules of the particular interview into 0 (not clinically significant) or 1 (clinically significant).

Table 14: Correlation of the SIAB-EX subscales (now) with standardized scales for eating disorders and general psychopathology (N = 37)

SIAB-EX	N	BI	Gen Psy Soc	Sex	Bul	Compen-satory behavior	Atyp. Binge
Eating Disorder Inventory (EDI)							
Total score	356	.28 **	.52 **	.29 **	.37 **	.27 **	.12 *
Drive for thinness	361	.38 **	.30 **	.19 **	.33 **	.36 **	-.01
Bulimia	359	.00	.24 **	.05	.65 **	.07	.19 **
Body dissatisfaction	356	-.10	.20 **	.03	.04	.02	.26 **
Ineffectiveness	356	.33 **	.57 **	.33 **	.22 **	.23 **	.01
Perfectionism	359	.16 **	.23 **	.14 *	.12 *	.10	.00
Interpersonal distrust	357	.15 **	.42 **	.24 **	.22 **	.15 **	.00
Interoceptive awareness	355	.33 **	.45 **	.28 **	.28 **	.31 **	.07
Maturity fears	353	.24 **	.25 **	.31 **	.03	.16 **	-.01
Asceticism	355	.38 **	.42 **	.27 **	.22 **	.26 **	-.03
Impulse regulation	357	.17 **	.40 **	.18 **	.25 **	.26 **	.07
Social insecurity	356	.28 **	.57 **	.30 **	.23 **	.26 **	.02
Three Factor Eating Questionnaire (TFEQ)							
Cognitive Control	355	.62 **	.13 *	.15 *	.07	.41 **	-.27 **
Disinhibition	356	-.19 **	.10	-.03	.51 **	-.07	.30 **
Hunger	357	-.14 **	.10	-.02	.41 **	-.13 *	.33 **
Symptom Check List SCL 90-R (SCL)							
General Symptomatic Index	339	.15 **	.30 **	.07	.11 *	.08	.09
Somatization	339	.12 *	.26 **	.02	.14 *	.04	.07
Obsessive-compulsive symptoms	338	.12 *	.27 **	.07	.09	.04	.10
Interpersonal sensitivity	339	.13 *	.31 **	.19 **	.09	.11 *	.01
Depression	339	.14 **	.33 **	.16 **	.13 *	.06	.06
Anxiety	339	.13 *	.27 **	.03	.09	.08	.13 *
Anger-hostility	339	.09	.15 **	-.01	.05	.04	.09
Phobis anxiety	339	.13 *	.18 **	-.03	.02	.06	.12 *
Paranoid ideation	339	.10	.21 **	.07	.07	.06	.05
Psychoticism	339	.14 **	.20 **	.02	.11 *	.07	.09
Beck-Depression-Index (BDI)	362	.38 **	.66 **	.34 **	.21 **	.37 **	.01
PERI Demoralization-Score (PERI)	363	.31 **	.68 **	.29 **	.24 **	.25 **	.00

* p < .05; ** p < .01
BI= Body image and slimness ideal, GenPsySoc=General Psychopathology and Social integration; Sex=Sexuality; Bul=Bulimic symptoms; Compensatory behavior=Inappropriate compensatory behavior to counteract weight gain, Fasting and Substance abuse; Atyp. Binge=Atypical binges

Table 15: Correlation of the SIAB-EX subscales (past) with standardized scales for eating disorders and general psychopathology (N = 377)

SIAB-EX	N	BI	Gen Psy Soc	Sex	Bul	Compen -satory behavior	Atyp. Binge
Eating Disorder Inventory (EDI)							
Total score	356	.28 **	.52 **	.29 **	.37 **	.27 **	.12 *
Drive for thinness	361	.38 **	.30 **	.19 **	.33 **	.36 **	-.01
Bulimia	359	.00	.24 **	.05	.65 **	.07	.19 **
Body dissatisfaction	356	-.10	.20 **	.03	.04	.02	.26 **
Ineffectiveness	356	.33 **	.57 **	.33 **	.22 **	.23 **	.01
Perfectionism	359	.16 **	.23 **	.14 *	.12 *	.10	.00
Interpersonal distrust	357	.15 **	.42 **	.24 **	.22 **	.15 **	.00
Interoceptive awareness	355	.33 **	.45 **	.28 **	.28 **	.31 **	.07
Maturity fears	353	.24 **	.25 **	.31 **	.03	.16 **	-.01
Asceticism	355	.38 **	.42 **	.27 **	.22 **	.26 **	-.03
Impulse regulation	357	.17 **	.40 **	.18 **	.25 **	.26 **	.07
Social insecurity	356	.28 **	.57 **	.30 **	.23 **	.26 **	.02
Three Factor Eating Questionnaire (TFEQ)							
Cognitive Control	355	.62 **	.13 *	.15 *	.07	.41 **	-.27 **
Disinhibition	356	-.19 **	.10	-.03	.51 **	-.07	.30 **
Hunger	357	-.14 **	.10	-.02	.41 **	-.13 *	.33 **
Symptom Check List SCL 90-R (SCL)							
General Symptomatic Index	339	.15 **	.30 **	.07	.11 *	.08	.09
Somatization	339	.12 *	.26 **	.02	.14 *	.04	.07
Obsessive-compulsive symptoms	338	.12 *	.27 **	.07	.09	.04	.10
Interpersonal sensitivity	339	.13 *	.31 **	.19 **	.09	.11 *	.01
Depression	339	.14 **	.33 **	.16 **	.13 *	.06	.06
Anxiety	339	.13 *	.27 **	.03	.09	.08	.13 *
Anger-hostility	339	.09	.15 **	-.01	.05	.04	.09
Phobis anxiety	339	.13 *	.18 **	-.03	.02	.06	.12 *
Paranoid ideation	339	.10	.21 **	.07	.07	.06	.05
Psychoticism	339	.14 **	.20 **	.02	.11 *	.07	.09
Beck-Depression-Index (BDI)	362	.38 **	.66 **	.34 **	.21 **	.37 **	.01
PERI Demoralization-Score (PERI)	363	.31 **	.68 **	.29 **	.24 **	.25 **	.00

* p < .05; ** p < .01
BI= Body image and slimness ideal, GenPsySoc=General Psychopathology and Social integration; Sex=Sexuality; Bul=Bulimic symptoms;
Compensatory behavior=Inappropriate compensatory behavior to counteract weight gain, Fasting and Substance abuse; Atyp. Binge=Atypical binges

Table 16: Interrater-reliability of the SIAB-EX (N=31); means, standard deviation and measures of congruence of the SIAB-EX and SIAB-S (past) for inpatients with eating disorders (N=377)

Item No.		Interrater reliability Kappa[1] (N=31)	N	Expert-rating EX M (SD)	Self-rating SR M (SD)	Correlation EX-SR (Pearson's R)	Kappa[1] EX/SR
	I Body Image and Slimness Ideal (BI)		**370**	**1.9 (0.8)**	**1.9 (0.8)**	**0.69****	**0.49****
16	Body image disturbance	0.62	358	2.2 (1.5)	1.5 (1.7)	0.52**	0.38**
7	Fear of gaining weight or getting fat – weight phobia	0.95	365	2.6 (1.3)	2.6 (1.4)	0.40**	0.33**
61	Preoccupation with body slimness, figure and body weight	1.00	367	2.7 (1.2)	2.9 (1.4)	0.30**	0.24**
(1)	Underweight (modified)/ deviance from normal body weight		355	1.9 (1.7)	1.8 (1.7)	0.98**	0.95**
12	Qualitative food reduction	0.76	363	2.6 (1.3)	2.4 (1.6)	0.35**	0.26**
59	Compulsive behavior concerning food or eating	0.50	366	1.2 (1.2)	1.3 (1.6)	0.37**	0.29**
42	Excessive exercise	0.78	364	1.7 (1.5)	1.8 (1.4)	0.55**	0.44**
60	Preoccupation with food or eating	1.00	367	3.1 (1.3)	2.6 (1.5)	0.36**	0.28**
14	Chewing and spitting out food	0.96	364	0.5 (1.1)	0.7 (1.3)	0.41**	0.37**
3	Internal achivement orientation	0.70	359	1.8 (1.3)	3.1 (1.1)	0.36**	0.09**
10	Dependence of self-esteem on figure and weight	1.00	222	2.8 (1.0)	2.9 (1.3)	0.30**	0.26**
13	Limits for caloric intake	1.00	355	2.0 (1.7)	1.9 (1.6)	0.50**	0.46**
19	Amenorrhea (modified)	0.81	357	1.3 (1.0)	1.2 (1.2)	0.48**	0.54**
55	Constipation	0.79	362	1.6 (1.6)	1.6 (1.5)	0.59**	0.55**
15	Regurgitation of food	1.00	365	0.2 (0.7)	0.2 (0.8)	0.74**	0.74**
17	Denial of threat to health caused by underweight		83	2.0 (1.9)	1.4 (1.8)	0.45**	0.42**
	II General Psychopathology (Gen Psy)		**370**	**1.5 (0.7)**	**1.6 (0.9)**	**0.68****	**0.43****
66	Reduced self-confidence in performance	0.63	367	2.2 (1.2)	2.4 (1.5)	0.48**	0.37**
65	Irrational depressive thoughts and dysfunctional cognitive schemata	0.72	367	2.2 (1.2)	2.6 (1.4)	0.40**	0.30**
64	Depressed mood	0.54	366	2.4 (1.1)	2.6 (1.4)	0.33**	0.25**
67	Reduction of self-esteem	0.76	365	2.5 (1.3)	2.5 (1.4)	0.46**	0.29**

4	Anxieties	0.49	365	1.4 (1.2)	2.0 (1.3)	0.43**	0.26**
6	Sleep disturbances	0.77	365	2.1 (1.6)	1.6 (1.5)	0.52**	0.38**
62	Feelings of insufficiency and helplessness	0.59	366	2.4 (1.2)	2.2 (1.5)	0.24**	0.13**
58	Obsessive thoughts	0.75	360	0.5 (0.9)	0.9 (1.3)	0.39**	0.33**
68	Suicidal thoughts	0.69	366	2.1 (1.5)	1.4 (1.4)	0.63**	0.53**
5	Phobias	0.66	365	1.2 (1.1)	1.7 (1.5)	0.42**	0.31**
56	Obsessive-compulsive checking	0.62	364	0.5 (0.9)	0.9 (1.3)	0.47**	0.28**
69	Suicidal acts	0.90	367	0.7 (1.1)	0.6 (1.0)	0.80**	0.66**
70	Other autoaggressive behavior	1.00	366	0.7 (1.2)	0.6 (1.1)	0.75**	0.61**
57	Obsessions about cleanliness	0.86	364	0.6 (1.0)	0.6 (1.1)	0.57**	0.42**
	III Sexuality and Social Integration (SexSoc)		**368**	**2.3 (0.8)**	**1.9 (0.9)**	**0.48****	**0.70****
78	Sexual behavior	0.66	344	1.8 (1.8)	1.5 (1.7)	0.29**	0.24**
76	Sexual anxieties	0.76	359	2.0 (1.6)	1.8 (1.5)	0.50**	0.45**
79	Leisure activities	0.64	364	2.6 (1.4)	2.0 (1.4)	0.27**	0.24**
82	Social withdrawal and avoidance of contacts	0.51	361	2.1 (1.4)	1.8 (1.5)	0.40**	0.30**
75	Reduced sexual desire	0.80	359	2.7 (1.7)	1.6 (1.6)	0.38**	0.23**
77	Partner relationship	0.68	363	1.9 (1.5)	1.5 (1.3)	0.46**	0.36**
81	Quality of social contacts	0.89	359	1.8 (1.8)	1.5 (1.3)	0.43**	0.44**
83	Denial of illness	0.79	356	2.8 (1.4)	2.6 (1.6)	0.09	-0.01
84	Global evaluation of symptoms	1.00	351	3.4 (0.8)	2.6 (1.4)	0.18**	0.08**
80	Extent of social contacts outside of family	0.70	363	2.0 (1.3)	2.0(1.3)	0.43**	0.34**
53	Objective impairment at school / at work / with household	0.68	347	2.5 (1.3)	1.3 (1.4)	0.26**	0.14**
63	Reduced perception of internal stimuli	1.00	367	2.3 (1.0)	2.1 (1.6)	0.36**	0.18**
	IV Bulimic Symptoms (Bul)		**369**	**2.4 (1.2)**	**2.0 (1.4)**	**0.70****	**0.69****
21a	Binging (objectively)	0.97	355	2.6 (1.5)	1.8 (1.4)	0.57**	0.51**
23	Average frequency of marked eating binges (3 months)		361	2.5 (1.5)	2.2 (1.6)	0.60**	0.53**
24	Frequency of marked eating binges (6 months)[2]		208	2.5 (1.4)	2.1 (1.6)	0.62**	0.53**
21b	Binging (subjectively)	0.88	364	2.8 (1.5)	2.2 (1.6)	0.58**	0.48**
26	Loss of control with regard to eating	0.88	322	2.3 (1.2)	2.2 (1.7)	0.49**	0.43**
28	Feelings of distress regarding binge eating	0.95	209	2.1 (1.5)	2.4 (1.6)	0.50**	0.44**
35	Self-induced vomiting	0.93	364	2.1 (1.9)	1.7(1.8)	0.78**	0.72**
34	Craving for food	0.83	220	2.5 (1.4)	2.3 (1.7)	0.43**	0.39**
22	Course of binge eating over time	1.00	80	2.1 (1.7)	1.9 (1.4)	0.69**	0.61**

	V Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting, Substance Abuse (Compensatory behavior)		**367**	**1.0 (0.6)**	**0.8 (0.6)**	**0.70****	**0.29****
38	Appetite suppressants	1.00	363	0.6 (1.1)	0.6 (1.2)	0.67**	0.51**
37	Diuretics	0.91	363	0.3 (0.8)	0.3 (0.9)	0.60**	0.44**
41	Excessive fasting	0.45	219	1.5 (1.6)	1.0 (1.3)	0.55**	0.49**
72	Tranquillizers with potential for dependency	0.97	363	0.4 (0.9)	0.7 (1.2)	0.44**	0.23**
73	Illegal drugs	1.00	364	0.3 (0.7)	0.3 (0.8)	0.74**	0.72**
36	Laxative abuse	0.66	362	1.2 (1.5)	0.9 (1.3)	0.72**	0.60**
11	Dieting or fasting - quantitative food reduction	1.00	362	3.1 (1.2)	2.4 (1.5)	0.35**	0.13**
71	Alcohol use/ abuse	0.89	362	1.3 (0.9)	1.1 (1.0)	0.64**	0.51**
39	Medication to increase thyroid metabolism	1.00	363	0.1 (0.4)	0.1 (0.6)	0.28	0.14**
43	Enemas	1.00	84	0.6 (0.4)	0.1 (0.3)	0.38**	-0.01
44	Ipecac	1.00	84	0.0 (0.0)	0.0 (0.2)	--	--
	VI Atypical Binges (Atyp. Binge)		**84**	**1.1 (1.1)**	**1.6 (1.1)**	**0.47****	**0.47****
31	Average number of marked atypical eating binges (3 months)		83	1.1 (1.4)	1.8 (1.7)	0.30**	0.34**
32	Frequency of marked atypical eating binges (6 months)[2]		82	1.0 (1.4)	1.6 (1.6)	0.28**	0.29**
29	Atypical eating binges	0.90	83	1.6 (1.8)	1.7 (1.5)	0.45**	0.35**
33	Eating more when feeling stressed or overburdend	1.00	84	1.6 (1.7)	2.1 (1.6)	0.57**	0.56**
30	Feeling comfortably full after binges		82	0.1 (0.6)	0.9 (1.3)	-0.01	-0.02
		370	**1.7 (0.5)**	**1.6 (0.7)**	**0.66****	**0.56****	

M=Mean; SD=Standard deviation; ** $p < 0.01$, * $p < 0.05$; n.s.=not significant; -- not calculated
[1] Kappa was calculated on the basis of recoded Items (0 and 1 = 0, not clinically significant; 2-4 = 1, clinically significant)
[2] Item is reported additonally (not included in any subscale)

Table 17: Interrater-reliability of the SIAB-EX (N=31); means, standard deviation and measures of congruence of the SIAB-EX and SIAB-S (now) for inpatients with eating disorders (N=377)

Item No.		Interrater-reliability Kappa[1] (N=31)	N	Expert-rating EX M (SD)	Self-rating SR M (SD)	Correlation EX-SR (Pearson's R)	Kappa[1] EX/SR
	I Body Image and Slimness Ideal (BI)		**370**	**1.2 (0.6)**	**1.4 (0.6)**	**0.71****	**0.40****
16	Body image disturbance	0.67	356	1.6 (1.4)	0.9 (1.4)	0.50**	0.36**
7	Fear of gaining weight or getting fat – weight phobia	0.66	366	1.9 (1.2)	2.4 (1.4)	0.37**	0.32**
61	Preoccupation with body slimness, figure and body Weight	0.73	369	2.0 (1.3)	2.5 (1.4)	0.32**	0.28**
12	Qualitative food-reduction	0.59	366	1.3 (1.4)	1.6 (1.5)	0.51**	0.48**
59	Compulsive behavior concerning food or eating	0.76	367	0.9 (1.1)	1.1 (1.4)	0.50**	0.41**
(1)	Underweight (modified)		363	0.9 (1.4)	1.0 (1.4)	0.95**	0.90**
13	Limits for caloric intake	0.72	361	0.5 (1.2)	0.8 (1.2)	0.52**	0.45**
60	Preoccupation with food and eating	0.82	369	2.3 (1.5)	2.2 (1.5)	0.48**	0.41**
19	Amenorrhea (modified)	0.65	353	0.9 (1.0)	0.9 (1.1)	0.66**	0.71**
3	Internal achievement orientation	0.60	307	1.3 (1.2)	2.4 (1.3)	0.26**	0.06
10	Dependence of self-esteem on figure and weight	0.75	222	2.4 (1.1)	2.5 (1.4)	0.42**	0.37**
14	Chewing and spitting out food	1.00	367	0.2 (0.8)	0.6 (1.3)	0.29**	0.29**
42	Excessive exercise	0.73	364	0.6 (1.0)	0.9 (1.2)	0.45**	0.35**
55	Constipation	0.79	363	0.8 (1.4)	1.2 (1.4)	0.65**	0.57**
63	Reduced perception of internal stimuli	0.68	369	2.0 (1.0)	2.1 (1.5)	0.48**	0.37**
83	Denial of illness	1.00	365	0.7 (1.0)	1.7(1.6)	-0.08	-0.04
15	Regurgitation of food	1.00	367	0.1 (0.5)	0.1 (0.6)	0.54**	0.51**
17	Denial of threat to health caused by underweight		84	0.7 (1.4)	1.0 (1.4)	0.45**	0.41**
	II General Psychopathology and Social Integration (Gen Psy Soc)		**370**	**1.1 (0.7)**	**1.5 (0.7)**	**0.77****	**0.37****
67	Reduction of self-esteem	0.86	365	1.9 (1.5)	2.2 (1.4)	0.54**	0.40**
66	Reduced self-confidence in performance	0.49	369	1.7 (1.3)	2.0 (1.4)	0.53**	0.44**
64	Depressed mood	0.75	368	1.6 (1.2)	2.2 (1.4)	0.54**	0.46**
65	Irrational depressive thoughts and dysfunctional cognitive schemata	0.69	369	1.5 (1.3)	2.2 (1.4)	0.37**	0.30**
82	Social withdrawal and avoidance of contacts	0.67	365	1.3 (1.4)	1.5 (1.4)	0.53**	0.48**

79	Leisure activities	0.60	359	1.9 (1.5)	2.3 (1.3)	0.48**	0.36**
4	Anxieties	0.67	367	1.1 (1.1)	2.1 (1.2)	0.43**	0.23**
68	Suicidal thoughts	0.66	368	0.6 (1.1)	0.8 (1.2)	0.53**	0.52**
62	Feelings of insufficiency and helplessness	0.61	368	1.8 (1.4)	2.1 (1.4)	0.38**	0.35**
80	Extent of social contacts outside of family	0.70	363	1.3 (1.3)	2.0 (1.3)	0.62**	0.49**
6	Sleep disorders	0.82	369	1.6 (1.5)	1.8 (1.4)	0.59**	0.51**
5	Phobias	0.69	366	1.0 (1.0)	1.5 (1.4)	0.42**	0.37**
53	Objective impairment at school/ at work/ with household	0.80	357	2.2 (1.4)	1.7 (1.4)	0.47**	0.34**
72	Tranquillizers with potential for dependency	1.00	365	0.1 (0.4)	0.4 (0.9)	0.29**	0.06
58	Obsessive thoughts	0.78	363	0.4 (0.8)	0.8 (1.2)	0.31**	0.25**
81	Quality of social contacts/confidants	0.94	364	0.7 (1.3)	0.8 (1.0)	0.35**	0.33**
57	Obsessions about cleanliness	0.77	365	0.4 (0.8)	0.5 (1.0)	0.50**	0.39**
56	Obsessive-compulsive checking	0.74	366	0.4 (0.7)	0.9 (1.2)	0.54**	0.35**
69	Suicidal Acts	1.00	369	0.01(0.2)	0.2 (0.5)	0.13*	-0.01
	III Sexuality (Sex)		**368**	**2.1 (1.3)**	**1.9 (1.3)**	**0.83****	**0.16****
78	Sexual behavior	0.73	346	2.3 (1.8)	2.1 (1.8)	0.73**	0.68**
77	Partner relationship	0.78	359	2.1 (1.7)	2.0 (1.8)	0.82**	0.78**
76	Sexual anxieties	0.79	361	1.7 (1.6)	1.7 (1.6)	0.63**	0.51**
75	Reduced sexual desire	0.68	363	2.3 (1.7)	1.6 (1.6)	0.64**	0.55**
	IV Bulimic Symptoms (Bul)		**369**	**1.9 (1.2)**	**2.0 (1.2)**	**0.81****	**0.58****
23	Average frequency of marked eating binges in a period of 3 months		365	1.8 (1.6)	2.0 (1.6)	0.73**	0.68**
24	Average frequency of marked eating binges in a period of 6 months [2]		204	1.8 (1.6)	2.1 (1.6)	0.77**	0.70**
21a	Eating binges (objectively)	0.98	357	1.8 (1.7)	1.6 (1.3)	0.64**	0.57**
21b	Eating binges (subjectively)	0.81	366	2.0 (1.7)	1.8 (1.6)	0.68**	0.63**
26	Loss of control with regard to eating	0.64	318	1.8 (1.4)	2.0 (1.7)	0.48**	0.36**
28	Feelings of distress regarding binge eating	0.88	206	1.7 (1.6)	2.2 (1.7)	0.60**	0.54**
35	Self-induced vomiting	0.97	363	1.5 (1.8)	1.5 (1.7)	0.89**	0.83**
34	Craving for food	0.80	219	1.9 (1.5)	2.0 (1.7)	0.54**	0.51**
84	Global evaluation of symptoms	0.67	356	3.3 (0.8)	3.1 (0.9)	0.35**	0.19**
22	Course of binge eating over time (SIAB-EX only)						
	V Inappropriate compensatory behaviors to Counteract Weight Gain, Fasting, Substance Abuse (Compensatory behavior)		**369**	**0.4 (0.3)**	**0.4 (0.3)**	**0.56****	**0.56****
38	Appetite suppressants	1.00	364	0.1 (0.5)	0.1 (0.4)	0.41**	0.54**

41	Excessive fasting	1.00	219	0.3 (0.9)	0.3 (0.8)	0.36**	0.37**
36	Laxative abuse	1.00	363	0.4 (1.0)	0.4 (1.0)	0.81**	0.81**
73	Illegal drugs	1.00	365	0.03 (0.2)	0.04 (0.2)	0.41**	0.50**
70	Other autoaggressive behavior	0.89	368	0.2 (0.8)	0.3 (0.7)	0.45**	0.30**
37	Diuretics	1.00	365	0.1 (0.3)	0.0 (0.5)	0.54**	0.39**
11	Quantitative food reduction	0.82	363	1.5 (1.6)	1.3 (1.4)	0.54**	0.44**
71	Alcohol use/ abuse	1.00	366	0.7 (0.7)	0.7 (0.7)	0.59**	0.51**
39	Medication to increase thyroid metabolism	1.00	365	0.0 (0.1)	0.1 (0.5)	0.22	--
43	Enemas	1.00	86	0.0 (0.4)	0.0 (0.1)	1.0**	--
44	Ipecac	1.00	85	0.0 (0.0)	0.0 (0.0)	--	--
	VI Atypical Binges (Atyp. Binge)		**86**	**0.8 (1.0)**	**1.4 (1.1)**	**0.62****	**0.45****
29	Atypical eating binges	1.00	85	0.9 (1.6)	1.3 (1.5)	0.50**	0.34**
31	Average number of marked atypical eating binges (3 months)		86	0.8 (1.3)	1.6 (1.6)	0.49**	0.45**
32	Frequency of marked atypical eating binges (6 months)[2]		85	0.8 (1.3)	1.6 (1.6)	0.47**	0.42**
33	Eating more when feeling stressed or overburdend	1.00	86	1.4 (1.7)	1.9 (1.6)	0.61**	0.54**
30	Feeling comfortably full after binges		86	0.1 (0.5)	0.6 (1.2)	0.17	0.07
		370	**1.2 (0.5)**	**1.4 (0.5)**	**0.80****	**0.35****	

M=Mean; SD=Standard deviation; ** $p < 0.01$, * $p < 0.05$; n.s.=not significant; -- not calculated
[1] Kappa was calculated on the basis of recoded items (0 and 1 = 0,clinically not significant; 2-4 = 1,clinically significant)
[2] Item is reported additionally (not included in any subscale)

Table 18: Means and standard deviations of the SIAB-EX and SIAB-S for patients with Anorexia Nervosa and Bulimia Nervosa (past)

		AN N=60			BN N=97		
Item No.		**N**	**Expert-rating M (SD)**	**Self-rating M (SD)**	**N**	**Expert-rating M (SD)**	**Self-rating M (SD)**
	I Body Image and Slimness Ideal (BI)	**60**	**2.6 (0.4)**	**2.2 (0.8)**	**95**	**2.1 (0.6)**	**2.1 (0.7)**
16	Body image disturbance	60	3.4 (0.8)	2.2 (1.6)	95	2.4 (1.2)	1.9 (1.7)
7	Fear of gaining weight or getting fat – weight phobia	60	3.6 (0.6)	2.6 (1.3)	95	3.0 (0.8)	3.1 (1.2)
61	Preoccupation with body slimness, figure and body weight	60	3.3 (0.8)	2.7 (1.4)	95	3.0 (1.0)	3.3 (1.1)
(1)	Underweight (modified)/ deviance from normal body weight	60	3.9 (0.4)	3.8 (0.5)	90	1.7 (1.4)	1.7 (1.5)
12	Qualitative food reduction	58	3.1 (1.2)	2.6 (1.6)	95	2.9 (1.1)	2.8 (1.4)
59	Compulsive behavior concerning food or eating	60	2.2 (1.0)	2.0 (1.6)	94	1.2 (1.3)	1.4 (1.6)
42	Excessive exercise	60	2.5 (1.4)	2.2 (1.4)	95	2.0 (1.4)	2.1 (1.4)
60	Preoccupation with food or eating	60	3.6 (0.7)	2.7 (1.5)	95	3.5 (1.0)	2.9 (1.4)
14	Chewing and spitting out food	59	0.9 (1.3)	0.9 (1.4)	94	0.8 (1.3)	1.1 (1.5)
3	Internal achievement orientation	59	2.3 (1.3)	3.4 (0.9)	92	1.8 (1.3)	3.1 (1.1)
10	Dependence of self-esteem on figure and weight	34	3.3 (0.9)	2.5 (1.5)	56	3.1 (0.7)	3.4 (0.9)
13	Limits for caloric intake	58	1.8 (1.9)	1.4 (1.6)	91	2.2 (1.7)	2.2 (1.6)
19	Amenorrhea (modified)	58	2.1 (0.6)	1.6 (1.2)	92	1.5 (1.0)	1.3 (1.2)
55	Constipation	59	2.1 (1.6)	1.7 (1.4)	93	2.0 (1.7)	1.9 (1.5)
15	Regurgitation of food	60	0.2 (0.7)	0.3 (0.9)	94	0.3 (1.0)	0.3 (0.9)
17	Denial of threat to health caused by underweight	14	3.4 (1.2)	2.0 (2.0)	23	2.1 (1.8)	1.9 (1.8)
	II General Psychopathology (Gen Psy)	**60**	**1.5 (0.7)**	**1.6 (0.8)**	**95**	**1.8 (0.8)**	**1.9 (0.9)**
66	Reduced self-confidence in performance	60	2.1 (1.1)	2.5 (1.3)	95	2.6 (1.2)	2.6 (1.4)
65	Irrational depressive thoughts and dysfunctional cognitive schemata	60	2.1 (1.2)	2.8 (1.3)	95	2.5 (1.3)	2.8 (1.2)
64	Depressed mood	60	2.1 (1.2)	2.4 (1.4)	95	2.4 (1.0)	2.9 (1.3)
67	Reduction of self-esteem	59	2.5 (1.2)	2.2 (1.3)	95	2.9 (1.2)	2.8 (1.4)
4	Anxieties	60	1.4 (1.3)	1.8 (1.1)	94	1.5 (1.4)	2.3 (1.3)
6	Sleep disturbances	60	2.0 (1.6)	1.6 (1.6)	93	2.4 (1.5)	1.7 (1.5)
62	Feelings of insufficiency and helplessness	60	2.3 (1.1)	2.3 (1.4)	94	2.6 (1.1)	2.6 (1.4)

Table 19: Mean and standard deviation of the SIAB-EX and SIAB-S of inpatients with Anorexia Nervosa and Bulimia Nervosa (now)

		AN N=60			BN N=97			Women without eating disorder N=111
		N	Expert-rating M (SD)	Self-rating M (SD)	N	Expert-rating M (SD)	Self-rating M (SD)	Expert-rating M (SD)
	I Body Image and Slimness Ideal (BI)	**60**	**1.9 (0.4)**	**1.9 (0.6)**	**95**	**1.3 (0.5)**	**1.7 (0.6)**	**0.5 (0.3)**
16	Body image disturbance	59	2.8 (1.1)	1.2 (1.5)	91	1.9 (1.2)	1.3 (1.5)	0.7 (0.8)
7	Fear of gaining weight or getting fat – weight phobia	60	3.1 (0.8)	2.5 (1.5)	94	2.2 (1.1)	2.9 (1.3)	
61	Preoccupation with body slimness, figure and body weight	60	2.7 (1.2)	2.5 (1.4)	94	2.4 (1.2)	3.0 (1.2)	0.7 (0.9)
12	Qualitative food-reduction	59	2.5 (1.3)	2.3 (1.5)	93	1.5 (1.5)	1.9 (1.5)	
59	Compulsive behavior concerning food or eating	60	1.9 (1.1)	2.4 (1.4)	92	0.7 (1.0)	1.3 (1.5)	0.2 (0.4)
(1)	Underweight (modified)	60	3.2 (0.8)	3.3 (0.9)	92	0.4 (0.7)	0.4 (0.8)	0.3 (0.7)
13	Limits for caloric intake	58	0.9 (1.5)	1.0 (1.4)	90	0.7 (1.4)	1.1 (1.4)	
60	Preoccupation with food and eating	60	3.0 (1.2)	2.9 (1.2)	94	2.7 (1.5)	2.8 (1.4)	0.5 (0.7)
19	Amenorrhea (modified)	58	1.9 (0.6)	2.2 (1.0)	91	0.7 (0.8)	0.7 (0.9)	0.2 (0.5)
3	Internal achievement orientation	51	1.6 (1.4)	2.4 (1.2)	76	1.5 (1.2)	2.3 (1.4)	0.7 (0.9)
10	Dependence of self-esteem on figure and weight	34	2.9 (1.0)	2.6 (1.3)	54	2.8 (0.8)	2.7 (1.3)	
14	Chewing and spitting out food	59	0.6 (1.1)	1.1 (1.4)	94	0.3 (1.0)	1.0 (1.6)	
42	Excessive exercise	58	0.9 (1.3)	0.9 (1.2)	93	0.6 (1.0)	1.0 (1.1)	0.9 (0.8)
55	Constipation	59	1.1 (1.6)	1.6 (1.6)	92	1.1 (1.6)	1.7 (1.5)	0.2 (0.7)
63	Reduced perception of internal stimuli	60	2.4 (0.8)	2.3 (1.5)	94	2.3 (0.9)	2.6 (1.4)	0.2 (0.5)
83	Denial of illness	58	1.1 (1.0)	1.8 (1.6)	93	0.4 (0.7)	1.9 (1.6)	
15	Regurgitation of food	60	0.1 (0.3)	0.1 (0.6)	93	0.2 (0.9)	0.3 (1.0)	
17	Denial of threat to health caused by underweight	14	1.2 (1.8)	1.7 (1.4)	23	0.5 (1.4)	0.7 (1.1)	
	II General Psychopathology and Social Integration (Gen Psy Soc)	**60**	**1.3 (0.6)**	**1.7 (0.7)**	**95**	**1.3 (0.7)**	**1.7 (0.7)**	**0.5 (0.3)**
67	Reduction of self-esteem	59	2.1 (1.3)	2.3 (1.5)	94	2.3 (1.5)	2.6 (1.3)	0.4 (0.6)
66	Reduced self-confidence in performance	60	1.8 (1.1)	2.4 (1.5)	94	2.1 (1.4)	2.3 (1.4)	0.7 (0.7)
64	Depressed mood	60	1.5 (1.2)	2.4 (1.4)	94	1.9 (1.2)	2.6 (1.3)	0.8 (0.7)
65	Irrational depressive thoughts and dysfunctional cognitive schemata	60	1.7 (1.2)	2.6 (1.4)	94	1.8 (1.5)	2.4 (1.4)	0.7 (0.8)
82	Social withdrawal and avoidance of contacts	59	1.8 (1.5)	2.0 (1.4)	93	1.5 (1.4)	1.7 (1.5)	0.4 (0.7)
79	Leisure activities	58	2.2 (1.4)	2.6 (1.2)	89	2.1 (1.5)	2.4 (1.4)	0.2 (0.5)
4	Anxieties	60	1.1 (1.0)	2.4 (1.2)	94	1.3 (1.2)	2.3 (1.1)	0.6 (0.7)
68	Suicidal thoughts	59	0.5 (1.1)	0.9 (1.0)	94	0.7 (1.3)	1.1 (1.2)	0.5 (0.8) [2]
62	Feelings of insufficiency and helplessness	60	2.0 (1.2)	2.3 (1.4)	93	2.1 (1.4)	2.5 (1.3)	0.5 (0.7)

80	Extent of social contacts outside of family	58	1.6 (1.4)	2.3 (1.3)	92	1.5 (1.3)	2.1 (1.3)	0.2 (0.6)
6	Sleep disorders	60	1.9 (1.5)	2.1 (1.5)	94	1.6 (1.6)	1.8 (1.3)	0.3 (0.7)
5	Phobias	60	1.0 (1.1)	1.3 (1.5)	92	1.1 (1.0)	1.8 (1.4)	0.5 (0.8)
53	Objective impairment at school/ at work/ with household	59	2.5 (1.3)	1.8 (1.4)	91	2.5 (1.3)	1.9 (1.3)	
72	Tranquillizers with potential for dependency	60	0.2 (0.5)	0.6 (1.0)	92	0.1 (0.9)	0.4 (0.9)	
58	Obsessive thoughts	59	0.4 (0.7)	0.9 (1.2)	93	0.5 (0.9)	1.0 (1.2)	0.5 (0.7)
81	Quality of social contacts/confidants	59	0.6 (1.1)	0.9 (1.0)	92	0.9 (1.4)	0.8 (1.0)	0.3 (0.6)
57	Obsessions about cleanliness	60	0.7 (0.8)	0.6 (1.0)	93	0.5 (0.9)	0.7 (1.2)	0.3 (0.5)
56	Obsessive-compulsive checking	59	0.5 (0.8)	1.1 (1.2)	94	0.4 (0.7)	0.9 (1.2)	0.3 (0.5)
69	Suicidal acts	60	0.1 (0.4)	0.1 (0.4)	94	0.0 (0.1)	0.3 (0.7)	
	III Sexuality (Sex)	**60**	**3.0 (1.0)**	**2.7 (0.9)**	**94**	**2.0 (1.3)**	**1.9 (1.2)**	**0.5 (0.7)**
78	Sexual behavior	57	3.3 (1.3)	3.1 (1.4)	93	2.2 (1.9)	2.1 (1.8)	0.4 (0.9)
77	Partner relationship	58	2.7 (1.6)	2.8 (1.6)	93	2.1 (1.7)	2.1 (1.7)	0.7 (1.4)
76	Sexual anxieties	58	2.6 (1.4)	2.5 (1.4)	94	1.7 (1.6)	1.7 (1.5)	0.4 (0.8)
75	Reduced sexual desire	59	3.5 (1.0)	2.5 (1.4)	94	2.1 (1.7)	1.6 (1.6)	0.3 (0.6)
	IV Bulimic Symptoms (Bul)	**60**	**1.8 (1.3)**	**1.7 (1.3)**	**94**	**3.2 (0.5)**	**3.0 (0.8)**	
23	Average frequency of marked eating binges in a period of 3 months	60	1.5 (1.6)	1.7 (1.6)	94	3.4 (0.8)	3.2 (1.0)	
24	Average frequency of marked eating binges in a period of 6 months [2]	30	1.5 (1.6)	1.8 (1.7)	55	3.4 (0.8)	3.2 (1.0)	
21a	Eating binges (objectively)	60	1.5 (1.7)	1.2 (1.3)	91	3.4 (0.8)	2.5 (1.1)	0.7 (0.8)
21b	Eating binges (subjectively)	60	1.7 (1.8)	1.4 (1.6)	94	3.5 (0.7)	3.1 (1.1)	
26	Loss of control with regard to eating	46	1.7 (1.2)	1.7 (1.8)	93	3.0 (0.7)	2.8 (1.5)	
28	Feelings of distress regarding binge eating	27	1.7 (1.7)	2.1 (1.9)	55	3.0 (1.1)	3.2 (1.2)	
35	Self-induced vomiting	59	1.4 (1.8)	1.4 (1.7)	94	3.1 (1.3)	3.0 (1.4)	0.1 (0.3)
34	Craving for food	34	1.7 (1.4)	1.7 (1.8)	55	2.8 (1.2)	2.9 (1.3)	
84	Global evaluation of symptoms	58	3.7 (0.5)	3.4 (0.6)	91	3.6 (0.5)	3.4 (0.7)	0.1 (0.2)
22	Course of binge eating over time (SIAB-EX only)							
	V Inappropriate compensatory behaviors to Counteract Weight Gain, Fasting, Substance Abuse (Compensatory behavior)	**60**	**0.5 (0.3)**	**0.5 (0.3)**	**94**	**0.5 (0.4)**	**0.5 (0.4)**	
38	Appetite suppressants	60	0.0 (0.3)	0.0 (0.0)	94	0.2 (0.9)	0.2 (0.7)	
41	Excessive fasting	34	0.5 (1.3)	0.4 (0.9)	55	0.4 (1.0)	0.6 (1.0)	
36	Laxative abuse	60	0.7 (1.3)	0.7 (1.4)	93	0.7 (1.3)	0.7 (1.2)	0.2 (0.5)
73	Illegal drugs	58	0.0 (0.1)	0.0 (0.0)	93	0.1 (0.4)	0.1 (0.3)	
70	Other autoaggressive behavior	60	0.2 (0.6)	0.4 (0.9)	93	0.4 (1.1)	0.4 (0.9)	
37	Diuretics	60	0.0 (0.1)	0.0 (0.1)	94	0.1 (0.6)	0.2 (0.7)	
11	Quantitative food reduction	59	3.1 (1.2)	2.1 (1.4)	92	1.7 (1.7)	1.5 (1.4)	0.5 (0.7)[3]
71	Alcohol use/ abuse	60	0.7 (0.7)	0.6 (0.7)	93	0.7 (0.7)	0.7 (0.8)	0.2 (0.5)

39	Medication to increase thyroid metabolism	59	0.0 (0.1)	0.1 (0.6)	93	0.0 (0.1)	0.0 (0.0)
43	Enemas	14	0.0 (0.0)	0.0 (0.0)	25	0.2 (0.8)	0.0 (0.2)
44	Ipecac	14	0.0 (0.0)	0.0 (0.0)	25	0.0 (0.0)	0.0 (0.0)
	VI Atypical Binges (Atyp. Binge)	**14**	**0.3 (0.5)**	**0.8 (1.0)**	**25**	**1.2 (1.0)**	**2.0 (1.0)**
29	Atypical eating binges	14	0.3 (1.1)	0.7 (1.4)	25	1.5 (1.9)	2.1 (1.6)
31	Average number of marked atypical eating binges (3 months)	14	0.3 (0.8)	0.8 (1.4)	25	1.2 (1.4)	2.3 (1.5)
32	Frequency of marked atypical eating binges (6 months)[2]	14	0.3 (0.8)	0.9 (1.5)	25	1.2 (1.4)	2.4 (1.6)
33	Eating more when feeling stressed or overburdend	14	0.4 (1.2)	1.5 (1.7)	25	2.1 (1.9)	2.5 (1.4)
30	Feeling comfortably full after binges	14	0.0 (0.0)	0.1 (0.3)	25	0.0 (0.0)	1.0 (1.5)
	Total Score	**60**	**1.4 (0.4)**	**1.6 (0.5)**	**95**	**1.4 (0.4)**	**1.7 (0.5)**

M=Mean; SD=Standard deviation; ** $p < 0.01$, * $p < 0.05$; n.s.=not significant; -- not calculated
[1] Kappa was calculated on the basis of recoded Items (0 and 1 = 0,clinically not significant; 2-4 = 1,clinically significant)
[2] Item is reported additionally (not included in any subscale)
[2]includes suicidal acts; [3] includes qualitative food-reduction

Table 19: Mean and standard deviation of the SIAB-EX and SIAB-S of inpatients with Anorexia Nervosa and Bulimia Nervosa (now)

		AN N=60			BN N=97			Women without eating disorder N=111
		N	Expert-rating M (SD)	Self-rating M (SD)	N	Expert-rating M (SD)	Self-rating M (SD)	Expert-rating M (SD)
	I Body Image and Slimness Ideal (BI)	**60**	**1.9 (0.4)**	**1.9 (0.6)**	**95**	**1.3 (0.5)**	**1.7 (0.6)**	**0.5 (0.3)**
16	Body image disturbance	59	2.8 (1.1)	1.2 (1.5)	91	1.9 (1.2)	1.3 (1.5)	0.7 (0.8)
7	Fear of gaining weight or getting fat – weight phobia	60	3.1 (0.8)	2.5 (1.5)	94	2.2 (1.1)	2.9 (1.3)	
61	Preoccupation with body slimness, figure and body weight	60	2.7 (1.2)	2.5 (1.4)	94	2.4 (1.2)	3.0 (1.2)	0.7 (0.9)
12	Qualitative food-reduction	59	2.5 (1.3)	2.3 (1.5)	93	1.5 (1.5)	1.9 (1.5)	
59	Compulsive behavior concerning food or eating	60	1.9 (1.1)	2.4 (1.4)	92	0.7 (1.0)	1.3 (1.5)	0.2 (0.4)
(1)	Underweight (modified)	60	3.2 (0.8)	3.3 (0.9)	92	0.4 (0.7)	0.4 (0.8)	0.3 (0.7)
13	Limits for caloric intake	58	0.9 (1.5)	1.0 (1.4)	90	0.7 (1.4)	1.1 (1.4)	
60	Preoccupation with food and eating	60	3.0 (1.2)	2.9 (1.2)	94	2.7 (1.5)	2.8 (1.4)	0.5 (0.7)
19	Amenorrhea (modified)	58	1.9 (0.6)	2.2 (1.0)	91	0.7 (0.8)	0.7 (0.9)	0.2 (0.5)
3	Internal achievement orientation	51	1.6 (1.4)	2.4 (1.2)	76	1.5 (1.2)	2.3 (1.4)	0.7 (0.9)
10	Dependence of self-esteem on figure and weight	34	2.9 (1.0)	2.6 (1.3)	54	2.8 (0.8)	2.7 (1.3)	
14	Chewing and spitting out food	59	0.6 (1.1)	1.1 (1.4)	94	0.3 (1.0)	1.0 (1.6)	
42	Excessive exercise	58	0.9 (1.3)	0.9 (1.2)	93	0.6 (1.0)	1.0 (1.1)	0.9 (0.8)
55	Constipation	59	1.1 (1.6)	1.6 (1.6)	92	1.1 (1.6)	1.7 (1.5)	0.2 (0.7)
63	Reduced perception of internal stimuli	60	2.4 (0.8)	2.3 (1.5)	94	2.3 (0.9)	2.6 (1.4)	0.2 (0.5)
83	Denial of illness	58	1.1 (1.0)	1.8 (1.6)	93	0.4 (0.7)	1.9 (1.6)	
15	Regurgitation of food	60	0.1 (0.3)	0.1 (0.6)	93	0.2 (0.9)	0.3 (1.0)	
17	Denial of threat to health caused by underweight	14	1.2 (1.8)	1.7 (1.4)	23	0.5 (1.4)	0.7 (1.1)	
	II General Psychopathology and Social Integration (Gen Psy Soc)	**60**	**1.3 (0.6)**	**1.7 (0.7)**	**95**	**1.3 (0.7)**	**1.7 (0.7)**	**0.5 (0.3)**
67	Reduction of self-esteem	59	2.1 (1.3)	2.3 (1.5)	94	2.3 (1.5)	2.6 (1.3)	0.4 (0.6)
66	Reduced self-confidence in performance	60	1.8 (1.1)	2.4 (1.5)	94	2.1 (1.4)	2.3 (1.4)	0.7 (0.7)
64	Depressed mood	60	1.5 (1.2)	2.4 (1.4)	94	1.9 (1.2)	2.6 (1.3)	0.8 (0.7)
65	Irrational depressive	60	1.7 (1.2)	2.6 (1.4)	94	1.8 (1.5)	2.4 (1.4)	0.7 (0.8)

	thoughts and dysfunctional cognitive schemata							
82	Social withdrawal and avoidance of contacts	59	1.8 (1.5)	2.0 (1.4)	93	1.5 (1.4)	1.7 (1.5)	0.4 (0.7)
79	Leisure activities	58	2.2 (1.4)	2.6 (1.2)	89	2.1 (1.5)	2.4 (1.4)	0.2 (0.5)
4	Anxieties	60	1.1 (1.0)	2.4 (1.2)	94	1.3 (1.2)	2.3 (1.1)	0.6 (0.7)
68	Suicidal thoughts	59	0.5 (1.1)	0.9 (1.0)	94	0.7 (1.3)	1.1 (1.2)	0.5 (0.8) [2]
62	Feelings of insufficiency and helplessness	60	2.0 (1.2)	2.3 (1.4)	93	2.1 (1.4)	2.5 (1.3)	0.5 (0.7)
80	Extent of social contacts outside of family	58	1.6 (1.4)	2.3 (1.3)	92	1.5 (1.3)	2.1 (1.3)	0.2 (0.6)
6	Sleep disorders	60	1.9 (1.5)	2.1 (1.5)	94	1.6 (1.6)	1.8 (1.3)	0.3 (0.7)
5	Phobias	60	1.0 (1.1)	1.3 (1.5)	92	1.1 (1.0)	1.8 (1.4)	0.5 (0.8)
53	Objective impairment at school/ at work/ with household	59	2.5 (1.3)	1.8 (1.4)	91	2.5 (1.3)	1.9 (1.3)	
72	Tranquillizers with potential for dependency	60	0.2 (0.5)	0.6 (1.0)	92	0.1 (0.9)	0.4 (0.9)	
58	Obsessive thoughts	59	0.4 (0.7)	0.9 (1.2)	93	0.5 (0.9)	1.0 (1.2)	0.5 (0.7)
81	Quality of social contacts/confidants	59	0.6 (1.1)	0.9 (1.0)	92	0.9 (1.4)	0.8 (1.0)	0.3 (0.6)
57	Obsessions about cleanliness	60	0.7 (0.8)	0.6 (1.0)	93	0.5 (0.9)	0.7 (1.2)	0.3 (0.5)
56	Obsessive-compulsive checking	59	0.5 (0.8)	1.1 (1.2)	94	0.4 (0.7)	0.9 (1.2)	0.3 (0.5)
69	Suicidal acts	60	0.1 (0.4)	0.1 (0.4)	94	0.0 (0.1)	0.3 (0.7)	
	III Sexuality (Sex)	**60**	**3.0 (1.0)**	**2.7 (0.9)**	**94**	**2.0 (1.3)**	**1.9 (1.2)**	**0.5 (0.7)**
78	Sexual behavior	57	3.3 (1.3)	3.1 (1.4)	93	2.2 (1.9)	2.1 (1.8)	0.4 (0.9)
77	Partner relationship	58	2.7 (1.6)	2.8 (1.6)	93	2.1 (1.7)	2.1 (1.7)	0.7 (1.4)
76	Sexual anxieties	58	2.6 (1.4)	2.5 (1.4)	94	1.7 (1.6)	1.7 (1.5)	0.4 (0.8)
75	Reduced sexual desire	59	3.5 (1.0)	2.5 (1.4)	94	2.1 (1.7)	1.6 (1.6)	0.3 (0.6)
	IV Bulimic Symptoms (Bul)	**60**	**1.8 (1.3)**	**1.7 (1.3)**	**94**	**3.2 (0.5)**	**3.0 (0.8)**	
23	Average frequency of marked eating binges in a period of 3 months	60	1.5 (1.6)	1.7 (1.6)	94	3.4 (0.8)	3.2 (1.0)	
24	Average frequency of marked eating binges in a period of 6 months [2]	30	1.5 (1.6)	1.8 (1.7)	55	3.4 (0.8)	3.2 (1.0)	
21a	Eating binges (objectively)	60	1.5 (1.7)	1.2 (1.3)	91	3.4 (0.8)	2.5 (1.1)	0.7 (0.8)
21b	Eating binges (subjectively)	60	1.7 (1.8)	1.4 (1.6)	94	3.5 (0.7)	3.1 (1.1)	
26	Loss of control with regard to eating	46	1.7 (1.2)	1.7 (1.8)	93	3.0 (0.7)	2.8 (1.5)	
28	Feelings of distress regarding binge eating	27	1.7 (1.7)	2.1 (1.9)	55	3.0 (1.1)	3.2 (1.2)	
35	Self-induced vomiting	59	1.4 (1.8)	1.4 (1.7)	94	3.1 (1.3)	3.0 (1.4)	0.1 (0.3)
34	Craving for food	34	1.7 (1.4)	1.7 (1.8)	55	2.8 (1.2)	2.9 (1.3)	
84	Global evaluation of symptoms	58	3.7 (0.5)	3.4 (0.6)	91	3.6 (0.5)	3.4 (0.7)	0.1 (0.2)
22	Course of binge eating over time (SIAB-EX only)							

	V Inappropriate compensatory behaviors to Counteract Weight Gain, Fasting, Substance Abuse (Compensatory behavior)	**60**	**0.5 (0.3)**	**0.5 (0.3)**	**94**	**0.5 (0.4)**	**0.5 (0.4)**	
38	Appetite suppressants	60	0.0 (0.3)	0.0 (0.0)	94	0.2 (0.9)	0.2 (0.7)	
41	Excessive fasting	34	0.5 (1.3)	0.4 (0.9)	55	0.4 (1.0)	0.6 (1.0)	
36	Laxative abuse	60	0.7 (1.3)	0.7 (1.4)	93	0.7 (1.3)	0.7 (1.2)	0.2 (0.5)
73	Illegal drugs	58	0.0 (0.1)	0.0 (0.0)	93	0.1 (0.4)	0.1 (0.3)	
70	Other autoaggressive behavior	60	0.2 (0.6)	0.4 (0.9)	93	0.4 (1.1)	0.4 (0.9)	
37	Diuretics	60	0.0 (0.1)	0.0 (0.1)	94	0.1 (0.6)	0.2 (0.7)	
11	Quantitative food reduction	59	3.1 (1.2)	2.1 (1.4)	92	1.7 (1.7)	1.5 (1.4)	0.5 (0.7)[3]
71	Alcohol use/ abuse	60	0.7 (0.7)	0.6 (0.7)	93	0.7 (0.7)	0.7 (0.8)	0.2 (0.5)
39	Medication to increase thyroid metabolism	59	0.0 (0.1)	0.1 (0.6)	93	0.0 (0.1)	0.0 (0.0)	
43	Enemas	14	0.0 (0.0)	0.0 (0.0)	25	0.2 (0.8)	0.0 (0.2)	
44	Ipecac	14	0.0 (0.0)	0.0 (0.0)	25	0.0 (0.0)	0.0 (0.0)	
	VI Atypical Binges (Atyp. Binge)	**14**	**0.3 (0.5)**	**0.8 (1.0)**	**25**	**1.2 (1.0)**	**2.0 (1.0)**	
29	Atypical eating binges	14	0.3 (1.1)	0.7 (1.4)	25	1.5 (1.9)	2.1 (1.6)	
31	Average number of marked atypical eating binges (3 months)	14	0.3 (0.8)	0.8 (1.4)	25	1.2 (1.4)	2.3 (1.5)	
32	Frequency of marked atypical eating binges (6 months)[2]	14	0.3 (0.8)	0.9 (1.5)	25	1.2 (1.4)	2.4 (1.6)	
33	Eating more when feeling stressed or overburdend	14	0.4 (1.2)	1.5 (1.7)	25	2.1 (1.9)	2.5 (1.4)	
30	Feeling comfortably full after binges	14	0.0 (0.0)	0.1 (0.3)	25	0.0 (0.0)	1.0 (1.5)	
	Total Score	**60**	**1.4 (0.4)**	**1.6 (0.5)**	**95**	**1.4 (0.4)**	**1.7 (0.5)**	

M=Mean; SD=Standard deviation; ** $p < 0.01$, * $p < 0.05$; n.s.=not significant; -- not calculated
[1] Kappa was calculated on the basis of recoded Items (0 and 1 = 0,clinically not significant; 2-4 = 1,clinically significant)
[2] Item is reported additionally (not included in any subscale)
[2]includes suicidal acts; [3] includes qualitative food-reduction

Table 20: Factors of the SIAB-S (past)

Item No.	Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
	I Bulimic Symptoms (Bul)						
21b	Binging (subjectively)	.86	.11	.14	.14	.01	.17
23	Average frequency of marked eating binges over a period of 3 months	.84	.08	.04	.13	.12	.18
21a	Binges (objectively)	.83	.01	.14	.08	-.05	.16
28	Feelings of distress regarding binge eating	.77	.23	.29	.07	.04	-.03
34	Craving for food	.71	.18	.25	.04	-.03	.14
35	Self-induced vomiting	.70	.04	-.00	.04	.42	.13
26	Loss of control with regard to eating	.63	.26	.26	.05	.05	.10
22	Course of binge eating over time	--	--	--	--	--	--
84	Global evaluation of symptoms associated with the eating disorder	.46	.25	.13	.22	.09	.05
83	Denial of illness	.41	.15	.17	.32	.32	.01
	II General Psychopathology (Gen Psy)						
67	Reduction of self-esteem	.21	.67	.18	.38	-.02	.00
65	Irrational depressive thoughts and dysfunctional cognitive schemata	.15	.67	.21	.18	.17	-.05
66	Reduced self-confidence in performance	.14	.67	.18	.37	.08	.01
62	Feelings of self-insuffiency and helplessness	.27	.62	.17	.18	.01	.09
58	Obsessive thoughts	.02	.62	.09	.10	.24	.21
64	Depressed mood	.32	.58	.26	.29	.06	.08
68	Suicidal thoughts	.20	.54	.02	.13	.08	.46
5	Phobias	.09	.53	.06	.11	-.09	.24
4	Anxieties	.16	.52	.15	.30	.01	.29
57	Obsessions about cleanliness	.10	.51	.03	-.08	.18	.28
56	Obsessive-compulsive checking	-.02	.50	.08	.17	.23	.19
63	Reduced perception of internal stimuli	.43	.45	.29	.25	.14	.15
6	Sleep disorders	.15	.36	.22	.24	-.05	.32
53	Objective impairment at school / at work / with household	.22	.24	.22	.21	.09	.22
	III Slimness Ideal (Slim)						
12	Avoidance of fattening food and selective eating – qualitative food-reduction	.23	.18	.72	.14	.25	.00
11	Dieting or fasting - quantitative food reduction	.18	.23	.71	.08	.26	.10
13	Limits for caloric intake	.21	.13	.66	.05	.16	.11
7	Fear of gaining weight or getting fat – weight phobia	.31	.29	.60	-.01	.21	.11
61	Preoccupation with body slimness, figure and body weight	.38	.36	.56	-.05	.12	-.03
60	Preoccupation with food and eating	.43	.30	.52	.11	.21	-.01

Item No.	Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
10	Dependence of self-esteem on figure and weight	.39	.20	.51	.05	-.01	-.06
39	Medication to increase thyroid metabolism	-.05	-.12	.35	.06	-.29	.15
3	Internal achievement orientation	-.04	-.06	.26	.21	.30	-.07
	IV Sexuality and Social Integration (SexSoc)						
80	Extent of social contacts outside of family	.16	.18	.12	.73	-.00	.06
82	Social withdrawal and avoidance of contacts	.21	.36	.15	.66	.11	.07
78	Sexual behavior	.03	.09	-.03	.62	.07	-.01
81	Quality of social contacts /confidants	.04	.13	-.07	.59	-.07	.17
79	Leisure activities	.17	.24	.24	.57	-.09	.05
76	Sexual anxieties	.07	.35	.06	.49	.23	.10
75	Reduced sexual desire	.03	.27	.18	.47	.31	.18
77	Partner relationship	.04	.05	-.03	.38	.13	-.09
	V Body Image (BI)						
(1)	Underweight (modified)	-.20	.00	.02	.12	.72	-.08
16	Body image disturbance	.14	.17	.23	.01	.64	-.08
14	Chewing and spitting out food	.30	.12	.04	-.00	.55	.06
19	Amenorrhea (modified)	.01	.00	.09	.32	.55	.13
59	Compulsive behavior concerning food or eating	.01	.23	.30	.19	.44	-.03
42	Excessive exercise	.06	.06	.19	-.08	.41	.00
15	Regurgitation of food	.11	.05	-.08	-.02	.35	.14
55	Constipation	.09	.13	.21	.21	.34	.23
17	Denial of threat to health caused by underweight	--	--	--	--	--	--
	VI Inappropriate Compensatory Behaviors to Counteract Weight Gain, Substance Abuse, Fasting and Other Autoaggressive Behavior (Compensatory behavior)						
38	Appetite suppressants	.12	.05	.21	-.07	-.14	.64
72	Tranquillizers with potential for dependency	.06	.27	.12	.13	-.02	.61
37	Diuretics	.04	.02	.24	-.03	.03	.60
69	Suicidal acts	.04	.35	-.16	.14	.05	.54
36	Laxative abuse	.11	.04	.32	.09	.34	.51
73	Illegal drugs	.07	.18	-.11	-.12	.11	.41
70	Other autoaggressive behavior	.18	.38	-.13	.09	.24	.40
71	Alcohol use/abuse	.11	.09	-.13	.15	-.02	.36
41	Excessive fasting	.23	.04	.39	.05	.01	.33
43	Enemas	--	--	--	--	--	--
44	Ipecac	--	--	--	--	--	--
	VII Atypical Binges (Atyp. Binge)	--	--	--	--	--	--

Item No.	Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
31	Average number of marked atypical eating binges	--	--	--	--	--	--
29	Atypical eating binges	--	--	--	--	--	--
33	Eating more than usual when feeling stressed or overburdend	--	--	--	--	--	--
30	Feeling comfortably full after eating binges	--	--	--	--	--	--

Table 22: Intercorrelations of the SIAB-S subscales

a) now SIAB-EX	N	Bul	BI	SexWeight	Compensatory behavior	Atyp. Binge	Total
General Psychopathology and Social Integration (GenPsySoc)	370	.40**	.42**	.38**	.41**	.13	.86**
Bulimic Symptoms (Bul)	369	--	.36**	.08	.36**	.75**	.66**
Body Image and Slimness Ideal (BI)	370	--	--	.30**	.32**	.12	.68**
Sexuality and Body Weight (SexWeight)	370	--	--	--	.20**	-.21	.53**
Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and, Substance Abuse (Compensatory behavior)	369	--	--	--	--	-.00	.55**
Atypical Binges (Atyp. Binge)	86	--	--	--	--	--	.41**

a) past SIAB-EX	N	GenPsy	Slim	Sex Soc	BI	Compensa-tory behavior	Atyp. Binge	Total
Bulimic Symptoms (Bul)	367	.55**	.57**	.40**	.35**	.42**	.72**	.77**
General Psychopathology (GenPsy)	370	--	.56**	.62**	.39**	.56**	.30**	.87**
Slimness Ideal (Slim)	369	--	--	.38**	.45**	.36**	.49**	.76**
Sexuality and Social Integration (SexSoc)	368	--	--	--	.36**	.33**	.17	.70**
Body Image (BI)	370	--	--	--	--	.26**	-.03	.60**
Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Autoaggressive Behavior (Compensatory behavior)	367	--	--	--	--	--	.33**	.63**
Atypical Binges (Atyp. Binge)	84	--	--	--	--	--	--	.59**

p < .05; ** p < .01

Table 23: Internal consistency of the SIAB-S subscales

	Past			Now		
	n	Number of Items	Cronbach`s Alpha	n	Number of Items	Cronbach`s Alpha
Bulimic Symptoms (Bul, past and now)	342	8	0.80	330	7	0.76
General Psychopathology (GenPsy, past) General Psychopathology und Sociale Integration (GenPsySoc, now)	346	14	0.90	174	8	0.91
Body Image (BI, past) Body Image and Slimness Ideal (BI, now)	178	9	0.90	339	21	0.89
Slimness Ideal (Slim, past)	80	4	0.70	--	--	--
Sexuality and Social Integration (SexSoc, past) Sexuality and Body Weight (SexWeight, now)	205	9	0.85	204	10	0.82
Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse (Compensatory behavior, now) Inappropriate Compensatory Behaviors to Counteract Weight Gain, Substance Abuse, Fasting and Other Autoaggressive Behavior (Compensatory behavior, past)	332	8	0.69	214	11	0.34
Atypical Binges (Atyp. Binge)	215	9	0.69	85	4	0.74
Total Score	64	61[a)]	0.94	68	61[a)]	0.92

[a)] Items 17, 22, 43 and 44 were excluded from the analysis

Table 24: Correlations between the SIAB-S subscales and several sociodemographic variables

a) now

SIAB-S	**N**	**GenPsy Soc**	**Bul**	**BI**	**SexWeight**	**Compen-satory behavior**	**Atyp. Binge**	**Total**
Body weight (BMI) (past)	367	-.15**	-.10	-.16**	-.40**	-.28**	.24*	-.26**
Body weight (BMI) (now)	368	-.11*	-.11*	-.22**	-.36**	-.29**	.23*	-.25**
Duration of eating disorder	367	.02	-.11*	-.20**	-.19**	-.09	.05	-.13*
Age	370	.02	-.13*	-.18**	-.17**	-.12*	-.05	-.12*

b) past

SIAB-S	**N**	**Bul**	**GenPsy**	**Slim**	**SexSoc**	**BI**	**Compen-satory behavior**	**Atyp. Binge**	**Total**
Body weight (BMI) (past)	367	-.04	-.06	-.11*	-.08	-.63**	-.06	.47**	-.18**
Body weight (BMI) (now)	368	-.07	-.07	-.09	-.11*	-.59**	-.01	.44**	-.18**
Duration of eating disorder	367	.01	.09	-.00	.06	-.23**	.21**	.11	.03
Age	370	-.12*	-.10	-.01	-.01	-.26**	.15**	-.08	-.08

*p < .05; ** p < .01

GenPsySoc= General Psychopathology and Social Integration; Bul= Bulimic Symptoms; BI=Body Image and Slimness Ideal; SexWeight= Sexuality and Body Weight; Compensatory behavior= Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse; Atyp.Binge= Atypical Eating Binges; Slim=Slimness Ideal; GenPsy = General Psychopathology, SexSoc= Sexuality and Social Integration

Table 25: Correlations of the SIAB-S subscales (now) and the expert-rating Eating Disorder Examination (EDE) (N = 81)

SIAB-S	*GenPsy Soc*	*Bul*	**BI**	**Sex Weight**	**Compen-satory behavior**	**Atyp.Binge**	**Total Score**
Eating Disorder Examination(EDE)							
Restraint	.43**	.25*	.53**	.40**	.51**	-.13	.52**
Eating Concern	.55**	.60**	.44**	.18	.50**	.34**	.68**
Weight Concern	.31**	.19	.38**	.13	.30**	.03	.35**
Shape Concern	.41**	.18	.41**	.24*	.34**	.07	.44**
EDE Total Scale	**.55****	**.41****	**.57****	**.31****	**.54****	**.10**	**.65****

* P < .05; ** p < .01
GenPsySoc=General Psychopathology and Soziale Integration; Bul=Bulimic Symptoms; BI=Body Image and Slimness Ideal; SexWeight= Sexuality and Body Weight; Compensatory behavior= Inappropriate Compensatory Behaviors to Counteract Weight Gain, Fasting and Substance Abuse; Atyp.Binge=Atypical Binges

Table 26: Correlation of the SIAB-S subscales (now) with standardized scales for eating disorders and general psychopathology (N = 377)

SIAB-S	N	GenPsy Soc	Bul	BI	SexWe ight	Compen-satory behavior	Atyp. Binge	Total score
Eating Disorder Inventory (EDI)								
Total Score	356	.67**	.47**	.51**	.22**	.34**	.37**	.71**
Drive for thinness	361	.43**	.44**	.70**	.16**	.35**	.26*	.62**
Bulimia	359	.32**	.76**	.29**	-.04	.29**	.67**	.50**
Body dissatisfaction	356	.26**	.12*	.23**	-.12*	.01	.26*	.21**
Ineffectiveness	356	.71**	.25**	.33**	.32**	.33**	.02	.62**
Perfectionism	359	.26**	.12*	.23**	.14*	.11*	.26*	.29**
Interpersonal distrust	357	.50**	.18**	.15**	.19**	.14**	.16	.41**
Interoceptive awareness	355	.58**	.38**	.42**	.29**	.34**	.19	.63**
Maturity fears	353	.34**	.07	.20**	.30**	.16**	-.02	.33**
Asceticism	355	.59**	.29**	.47**	.31**	.31**	.23	.62**
Impulse regulation	357	.53**	.32**	.28**	.21**	.31**	.37**	.53**
Social insecurity	356	.67**	.24**	.25**	.26**	.25**	.15	.57**
Three Factor Eating Questionnaire (TFEQ)								
Cognitive Control	355	.19**	.09	.60**	.34**	.25**	-.16	.38**
Disinhibition	356	.20**	.59**	.12*	-.16**	.11*	.68**	.29**
Hunger	357	.17**	.52**	.09	-.09	.08	.62**	.26**
Symptom Check List SCL 90-R (SCL)								
General Symptomatic Index	337	.35**	.13*	.13*	.18**	.09	-.15	.30**
Somatization	337	.29**	.12*	.10	.12*	.07	-.06	.25**
Obsessive-compulsive symptoms	336	.33**	.13*	.10	.16**	.06	-.15	.28**
Interpersonal senstivity	337	.40**	.16**	.15**	.22**	.14*	-.18	.37**
Depression	337	.41**	.18**	.14*	.16**	.14*	-.02	.37**
Anxiety	337	.30**	.08	.11*	.13*	.08	-.08	.25**
Anger-hostility	337	.20**	.04	.09	.14*	.03	-.22*	.17**
Phobis anxiety	337	.19**	.01	.09	.11*	-.02	-.24*	.15**
Paranoid ideation	337	.23**	.07	.09	.15**	.05	-.17	.20**
Psychoticism	337	.21**	.08	.09	.16**	.04	-.14	.19**
Beck-Depression-Index (BDI)	362	.75**	.22**	.35**	.35**	.40**	-.13	.66**
PERI Demoralization-Score (PERI)	363	.79**	.28**	.29**	.29**	.32**	.17	.67**

*p < .05; ** p < .01

GenPsySoc=General Psychopathology and social integration; Bul=Bulimic symptoms; BI=Body image and slimness ideal; SexWeight=Sexuality and Body weight; Compensatory behavior= Inappropriate Compensatory Behaviors to counteract weight gain, fasting and substance abuse; Atyp. Binge= Atypical eating binges

Table 27: Correlation of the SIAB-S subscales (past) with standardized scales for eating disorders and general psychopathology (N = 377)

SIAB-S	N	Bul	GenPsy	Slim	SexSoc	BI	Compen-satory behavior	Atyp. Binge	Total Score
Eating Disorder Inventory (EDI)									
Total Score	356	.30**	.47**	.24**	.27**	.16**	.33**	.25*	.41**
Drive for thinness	361	.27**	.31**	.31**	.11*	.21**	.28**	.23*	.34**
Bulimia	359	.52**	.30**	.26**	.12*	.09	.28**	.55**	.37**
Body dissatisfaction	356	.09	.16**	.10	.06	-.22**	.21**	.32**	.11*
Ineffektiveness	356	.13*	.42**	.10	.27**	.19**	.24**	-.16	.31**
Perfectionism	359	.18**	.30**	.21**	.17**	.25**	.12*	.16	.29**
Interpersonal distrust	357	.07	.26**	-.02	.32**	.06	.14**	.07	.20**
Interoceptive awareness	355	.24**	.43**	.15**	.24**	.20**	.27**	.06	.36**
Maturity fears	353	-.04	.24**	.04	.12*	.21**	.03	-.11	.14**
Ascetizism	355	.10	.33**	.12*	.19**	.26**	.21**	-.01	.27**
Impulse regulation	357	.22**	.42**	.20**	.21**	.21**	.31**	.16	.36**
Social insecurity	356	.12*	.40**	.04	.37**	.11*	.20**	-.03	.29**
Three Factor Eating Questionnaire (TFEQ)									
Cognitive Control	355	.10	.16**	.34**	.13*	.43**	.12*	-.07	.27**
Disinhibition	356	.46**	.25**	.23**	.12*	-.11*	.21**	.64**	.29**
Hunger	357	.35**	.13*	.12*	.01	-.11*	.18**	.53**	.17**
Symptom Check List SCL 90-R (SCL)									
General Symptomatic Index	337	.13*	.23**	.05	.12*	.10	.12*	-.05	.19**
Somatization	337	.12*	.20**	.05	.08	.05	.12*	.05	.15**
Obsessive-compulsive symptoms	336	.15**	.23**	.04	.12*	.10	.12*	-.02	.19**
Interpersonal senstivity	337	.15**	.24**	.04	.19**	.10	.15**	.03	.21**
Depression	337	.15**	.23**	.06	.20**	.14*	.16**	.08	.22**
Anxiety	337	.09	.22**	.03	.09	.10	.12*	-.07	.16**
Anger-hostility	337	.06	.10	.01	.01	.05	.02	-.19	.07
Phobis anxiety	337	.03	.15**	.01	.06	.05	.05	-.22	.09
Paranoid ideation	337	.11*	.13*	.02	.04	.07	.01	-.03	.10
Psychoticism	337	.10	.15**	.03	.06	.11	.06	-.11	.12*
Beck-Depression-Index (BDI)	362	.08	.34**	.08	.21**	.17**	.31**	-.25*	.26**
PERI Demoralization-Score (PERI)	363	.12*	.39**	.08	.22**	.21**	.26**	-.08	.29**

* p < .05; ** p < .01
Bul=Bulimic symptoms; GenPsy=General Psychopathology; Slim=slimness ideal; SexSoc=Sexuality and social integration; BI=Body image and slimness ideal; Compensatory behavior= Inappropriate Compensatory Behaviors to counteract weight gain, substance abuse, fasting and other autoaggressive behavior; Atyp. Binge=Atypical Binges

Foot note 1:

The factor structure of the SIAB-EX presented is based on a sample of 330 persons with eating disorders. These persons were patients in two different treatment centers in Germany, the Klinik Roseneck, Center for Behavioral Medicine, and the Clinic of Psychotherapy and Psychosomatics of the University of Essen. We thank Prof. Stephan Herpertz, University of Essen and Prof. Beate Herpertz-Dahlmann, University of Marburg for their support with up-dating the SIAB-EX.

Figure 1: Example for filling out the scoring sheet of the SIAB-EX

Figure 2: Example for filling out the scoring sheet of the SIAB-S