Family Meals Focus

The Ellyn Satter Institute Newsletter

What does ecSatter research say about eating disorders?

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To the extent that we urge, persuade, and guilt-trip ourselves and others to eat certain amounts and types of food and force our bodies to turn out a certain way, we all contribute to distortion, conflict, and anxiety with respect to eating. This is not to say that we *cause* eating disorders. Distorted eating attitudes and behaviors are symptoms of underlying psychosocial distortion, with each exacerbating the other. As Hilde Bruch observed, an eating disorder is "the misuse of eating in an attempt to solve or camouflage problems of daily living that seem otherwise insoluble."[1]

Subjects with high eating competence subjects score low on TFEQ

Two well-known validated tests addressing eating attitudes and behavior were among the instruments used to validate both the original[2] and the updated[3] ecSI 2.0™: Stunkard's Three Factor Eating Questionnaire (TFEQ)[4] and Garner's Eating Disorders Inventory (EDI).[5,6] From the perspective that achieving a particular body weight requires ignoring and overruling internal regulators, TFEQ tests for cognitive restraint with eating, disinhibition of restraint, and coping with hunger. EC subjects score in the "free eater" range for all three. EC subjects trust their internal regulators of hunger, appetite and satiety and tolerate between-meal hunger, not from willpower, but from a pleasant anticipation of the next satisfying meal or snack.

Subjects with high eating competence score low on EDI

Validation with EDI-2[6] and EDI-3[5] allow direct comparison of ecSI 2.0™ scores with eating disorder indicators. EDI-2[6] and EDI-3[5] are two-prong eating disorder inventories measuring eating and body image attitudes and behaviors as well as underlying psychosocial distortion. The higher subjects score on both the original[2] and updated[3] ecSI 2.0™, the lower they score on EDI-defined indicators of both eating/weight distortion and psychosocial limitations associated with eating disorders. Subjects who score in the lowest ecSI 2.0™ tertile (16 or below)[3] score within typical EDI-2 and EDI-3 clinical ranges for these indicators:

- Bulimia
- Body dissatisfaction
- Low self-esteem
- Personal alienation (emotional emptiness and aloneness)
- Interpersonal insecurity (difficulties expressing thoughts and feelings)
- Interpersonal alienation (lack of trust in relationships)
- Maturity fears (desire to retreat to childhood)

The eating competence interview study

Cognitive interviews with low-income women[7] reveal striking attitudinal differences between low-income women who score high and those who score low on ecSI. Women who score high relate their eating to energy, excitement, enjoyment, happiness, and relaxation. Those who score low report eating-disorder-typical eating attitudes and behaviors:

- Negative thoughts and feelings about eating
- Making weight management primary
- Emphasizing restricting and avoiding food
- Disorganized, inattentive eating
- Distress about failure to adhere to food management rules

Hypothesis: ecSI 2.0™ helps detect eating disorders

A person who scores in the lowest tertile of ecSI 2.0™ (16 or below)[3] may exhibit eating, body image, and psychosocial attitudes and behaviors associated with eating disorders. Identifying ecSI 2.0™ cutoffs that warrant exploration of eating disorder diagnosis requires further study.

- Use EDI[5] or the validated but uncopyrighted EAT-26[8] along with ecSI 2.0™.
- As with any other paper-and-pencil test, cautiously interpret low ecSI 2.0™ scores, even when used in conjunction with EDI and/or EAT-26, as indicating an eating disorder. Only clinical examination can determine whether the person truly has an eating disorder.
- Until the scoring norms are established by further research, accumulate your own body of knowledge about typical ecSI 2.0™ scores you observe in people with eating disorders.
- Because ecSI 2.0 has been demonstrated to have test/retest reliability,[9] you may administer ecSI 2.0™ before, during, and after intervention to support evidence-based clinical practice.

References

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