

EAT-26(c) Scoring and Interpretation

The Eating Attitudes Test (EAT-26) is probably the most widely used standardized measure of symptoms and concerns characteristic of eating disorders (Garner & Garfinkel, 1979; Garner, Olmsted, Bohr, & Garfinkel, 1982). The original EAT appeared as a Current Contents Citation Classic in 1993 (Garner, 1993). The 26-item version (Garner et al., 1989) is highly reliable and valid (Garner, Olmsted, Bohr, & Garfinkel, 1982; Lee et al., 2002; Mintz & O'Halloran, 2000). The EAT-26 alone does not yield a specific diagnosis of an eating disorder (neither the EAT-26, nor any other screening instrument, has been established as highly efficient as the sole means for identifying eating disorders).

Nevertheless, many studies have used the EAT-26 as an economical first step in a two-stage screening process. According to this methodology, individuals who score 20 or more on the test should be interviewed by a qualified professional to determine if they meet the diagnostic criteria for an eating disorder (Dotti & Lazzari, 1998; Patton, Johnson-Sabine, Wood, Mann, & Wakeling, 1990). If you have a low score on the EAT-26 (below 20), you still could have a serious eating problem, so do not let the results deter you from seeking help. The EAT-26 can be used in group or individual settings and is designed to be self-administered or be administered by health professionals, school counselors, coaches, camp counselors, and others with interest in gathering information to determine if an individual should be referred to a specialist for evaluation for an eating disorder.

The EAT-26 has been a particularly useful screening tool to assess "eating disorder risk" in high school, college and other special risk samples such as athletes (Garner, Rosen and Barry, 1998). Screening for eating disorders is based on the assumption that early identification of an eating disorder can lead to earlier treatment, thereby reducing serious physical and psychological complications or even death.

The EAT-26 items form three subscales (i.e. Dieting, Bulimia and Food Preoccupation and Oral Control) and subscale scores are computed by summing all items assigned to that particular scale (Dieting scale items: 1, 6, 7, 10, 11, 12, 14, 16, 17, 22, 23, 24, 25; Bulimia & Food Preoccupation scale items: 3, 4, 9, 18, 21, 26; Oral Control subscale items: 2, 5, 8, 13, 19, 20).

Because denial can be a problem on self-report screening instruments, low scores should not be taken to mean that either clinically significant eating disorders symptoms or a formal eating disorder is not present. Collateral information from parents, teammates, and coaches is useful information that can correct for denial, limited self-disclosure, and social desirability. High scores on self-report measures do not necessarily mean the respondent has an eating disorder; however, it does denote concerns regarding body weight, body shape, and eating. However, if you do have a high score, do not panic. It does not necessarily mean that you have a life-threatening condition and that you will have to immediately seek a form of treatment that may be uncomfortable. If you have a score of 20 or higher, this simply means that you should seek the advice of a qualified mental health professional who has experience with treating eating disorders.

In addition to the EAT-26 questions, identification of those at risk for eating disorders is based on information on the individual's body mass index (BMI) and behavioral symptoms reflective of an eating disorder.

Following the methodology described for the Eating Disorder Inventory Referral Form (EDI-RF; Garner, 2004) four behavioral questions are included on this version of the EAT-26 aimed at determining the presence of extreme weight-control behaviors as well as providing an estimate of their frequency. These questions assess self-reported binge eating, self-induced vomiting, use of laxatives, and treatment for an eating disorder over the preceding 6 months. Although these content areas could be assessed in the same format as other items, this would not provide the type of frequency data required to evaluate the extent of the problem. Body Mass Index (BMI) is also computed and used to determine if the person is "significantly underweight" compared to age-matched norms.

Generally a referral is recommended if a respondent scores "positively" on the EAT-26 items or meets the threshold on one or more of the behavioral criteria.

All self-report measures require open and honest responses in order to provide accurate information. The fact that most people provide honest responses means that the EAT-26 usually provides very useful information about the eating symptoms and concerns that are common in eating disorders.

Again, if you score at or above 20 on the EAT-26, please contact your physician or an eating disorders treatment specialist for a follow-up evaluation.